EXHIBIT 26
DATE 1/26/2011
HB 227

HOUSE BILL NO. 227

Handout prepared by Montana Families for Health Freedom

Purpose: **To protect the constitutional right of parents to practice their religion with a focus on the religious exemption to vaccination for children in day care.**

Questions:

Does present Montana Law allow the religious exemption in day care? Yes. See Page 3, top.

Do present Administrative Rules of Montana (ARM) allow the religious exemption in day care? No, with one exception, the Hib vaccine. See page 3, (bottom).

Is the law clarification requested in HB 227 basically different from the law or administrative rules provided in 48 other states and the District of Columbia? No. See Handout:
Daycare Availability to Religious Exemption in 48 of 50 States.

Do vaccines contain material from human cell lines that originated in tissue from aborted babies? Yes. See handout: Is Material from aborted babies used in vaccine culture in the USA?

Do vaccines contain blood products? YES See page 4.

Which of the vaccines that contain blood or material from continuous cells lines are on the CDC recommended schedule for children aged birth through 6 years. See page 5.

Does HB 227 make decisions for day care operators or parents? NO See page 6, top.

Does HB 227 make it more dangerous or a death sentence for children to attend day care?
No. See Page 6, bottom.

Vaccination is the Not the will of the Majority. See handout with same title.

Is there any natural immunity, apart of having had a case of disease, in the unvaccinated? Yes, see Summary of Natural Immunity in the unvaccinated.

Do unvaccinated children have more measles than vaccinated children? No. See MMR vaccine handout.

Can vaccines save lives? No, see handout on:
Mortality declined for children due to improved Sanitation and Nutrition.

Are there parents in Montana who have given in to pressure to vaccinate their children and seen their children suffer adverse reactions? Yes. [We expect oral presentation to confirm this fact.]

Are there parents in Montana who have suffered financial hardships due to being denied day care? Yes. [We expect oral presentation to confirm this fact.]

Why have we requested elimination of the word "*notarized*" in HB 227? See page 8.

Why have we requested elimination of the phrase "*on a form prescribed by the department*" in HB 227? See page 8.

Questions continued next page:

Questions: (cont')

Why have we requested addition of the phrase "in whole or in part" in HB 227? See page 8

Why have we requested elimination of the sentence "*A person who falsely claims a religious exemption is subject to the penalty for false swearing provided in 45-7-202.*"? See page 8

Does Montana rank 48th in vaccine uptake and what does this mean?
See handout: Estimated Vaccination Coverage for Montana Children – Year 2009

See our Handout:
Why the Religious Exemption to Vaccination in Day Care Must be Protected and Strengthened for the following questions:

Q. Why is the religious exemption to vaccination important?

Q. What is the problem with the religious exemption in Montana?

Q. Can the operator of a non-profit day care run by a religious organization whose tenants are opposed to vaccination accept children into their day care using the religious exemption for all vaccines and not just the Hib?

Q. Can't a parent just utilize a non-licensed day care/preschool for their child(ren)?

Q. What are the undesirable results of current administrative rules?

Q. Will vaccination rates be severely lowered by broadening the availability of exemptions?

Q. Will herd immunity be compromised in Montana because of religious exemptions?

Q. Will religious exemptions in the day care setting be a death sentence for incompletely immunized or immunocompromised children?

Q. Will immunocompromised children, who cannot be vaccinated for medical reasons, catch diseases from exemptors?

Q. Will exemptions cause diseases formerly conquered to return?

Q. Isn't public health more important than individual rights?

Q. Are there any doctors opposed to vaccine mandates?

Q. Can we dispense with the religious exemption and have only medical exemptions to vaccination?

Q. Is everybody eligible to use a religious exemption?

Q. How does science relate to the medical and religious exemptions?

Q. How does science relate to the medical and religious exemptions?

Q. If public health is not at stake, then why do we have vaccine mandates?

Does present Montana Law allow **the religious exemption in day care? Yes.**

The relevant section of current Montana law is:

> **52-2-735. Health protection -- certification required.** (1) The department shall adopt rules for the protection of children in day-care centers from the health hazards of inadequate food preparation, poor nutrition, and communicable diseases. Rules adopted by the department must include rules requiring children under 5 years of age to be immunized against Haemophilus influenza type "b" before being admitted for care in the facility **unless an exemption has been claimed as provided in 20-5-405.** [emphasis added]

Most lay people reading the second sentence of 52-2-735, MCA, conclude that Montana Law allows children to attend day-care with either a religious or medical exemption becaise both religious and medical exemptions are provided for in 20-5-405, MCA. However, the Department of Public Health and Human Services (DPHHS) interprets that 20-5-405 only requires the religious exemption to be given for the Haemophilus influenza type "b" (Hib) vaccine.

Conclusion: The law (52-2-735, MCA) **allows** the religious exemption to all vaccines in the day care setting and not just the Hib vaccine.
A lay opinion: An interpretation of law that is constitutionally valid and logical requires one to recognize that it was probably intended by a previous legislature to **require** the religious exemption be offered not only for the Hib vaccine but to any other vaccine requirement added by DPHHS in their rule making. HB 227 will clarify the law so that there will no longer be an ambiguity.

Do present Administrative Rules of Montana (ARM) allow the religious exemption in day care?
No, with one exception, the Hib vaccine. See excerpt of ARM 37.95.140 below:

> *(12) A child seeking to attend a day care facility is not required to have any immunizations which are medically contraindicated. A written and signed statement from a physician that an immunization is medically contraindicated will exempt a person from the applicable immunization requirements of this rule.*
>
> *(13) A child under five years of age seeking to attend a day care facility is not required to be immunized against Haemophilus influenza type B if the parent or guardian of the child objects thereto in a signed, written statement indicating that the proposed immunization interferes with the free exercise of the religious beliefs of the person signing the statement.*

Vaccine Excipient & Media Summary, Part 2 [Excerpt]

Excipients Included in U.S. Vaccines, by Vaccine

[Excerpt for **Blood Products in Vaccines**]

Includes vaccine ingredients (e.g., adjuvants and preservatives) as well as substances used during the manufacturing process, including vaccine-production media, that are removed from the final product and present only in trace quantities. In addition to the substances listed, most vaccines contain Sodium Chloride (table salt).

Vaccine	Contains
DtaP-IPV/Hib (Pentacel)	Aluminum Phosphate, **Bovine Serum Albumin**, Formaldehyde, Glutaraldhyde, MRC-5 DNA and Cellular Protein, Neomycin, Polymyxin B Sulfate, Polysorbate 80, 2-Phenoxyethanol,
Hep A (Vaqta)	Aluminum Hydroxyphosphate Sulfate, **Bovine Albumin or Serum**, DNA, Formaldehyde or Formalin, MRC-5 Cellular Protein, Sodium Borate
Japanese Encephalitis (JE-Vax)	Formaldehyde or Formalin, Gelatin, **Mouse Serum Protein**, Polysorbate 80, Thimerosal
Japanese Encephalitis (Ixiaro)	Aluminum Hydroxide, **Bovine Serum Albumin**, Formaldehyde, Protamine Sulfate, Sodium Metabisulphite
MMR (MMR-II)	Amino Acid, **Bovine Albumin or Serum**, Chick Embryo Fibroblasts, Human Serum Albumin, Gelatin, Glutamate, Neomycin, Phosphate Buffers, Sorbitol, Sucrose, Vitamins
MMRV (ProQuad)	**Bovine Albumin or Serum**, Gelatin, **Human Serum Albumin**, Monosodium L-glutamate, MRC-5 Cellular Protein, Neomycin, Sodium Phosphate Dibasic, Sodium Bicarbonate, Sorbitol, Sucrose, Potassium Phosphate Monobasic, Potassium Chloride, Potassium Phosphate Dibasic
Rabies (Imovax)	**Human Serum Albumin**, Beta-Propiolactone, MRC-5 Cellular Protein,Neomycin, Phenol Red (Phenolsulfonphthalein), Vitamins
Rabies (RabAvert)	Amphotericin B, Beta-Propiolactone, **Bovine Albumin or Serum**, Chicken Protein, Chlortetracycline, Egg Albumin (Ovalbumin), Ethylenediamine-Tetraacetic Acid Sodium (EDTA), Neomycin, Potassium Glutamate
Rotavirus (RotaTeq)	Cell Culture Media, **Fetal Bovine Serum**, Sodium Citrate, Sodium Phosphate Monobasic Monohydrate, Sodium Hydroxide Sucrose, Polysorbate 80
Vaccinia (ACAM2000) [smallpox vaccine]	Glycerin, **Human Serum Albumin**, Mannitol, Monkey Kidney Cells, Neomycin, Phenol, Polymyxin B
Varicella (Varivax)	**Bovine Albumin or Serum**, Ethylenediamine-Tetraacetic Acid Sodium (EDTA), Gelatin, Monosodium L-Glutamate, MRC-5 DNA and Cellular Protein,Neomycin, Potassium Chloride, Potassium Phosphate Monobasic, Sodium Phosphate Monobasic, Sucrose
Zoster (Zostavax)	**Bovine Calf Serum**, Hydrolyzed Porcine Gelatin, Monosodium L-glutamate, MRC-5 DNA and Cellular Protein, Neomycin, Potassium Phosphate Monobasic, Potassium Chloride, Sodium Phosphate Dibasic, Sucrose

March 2010

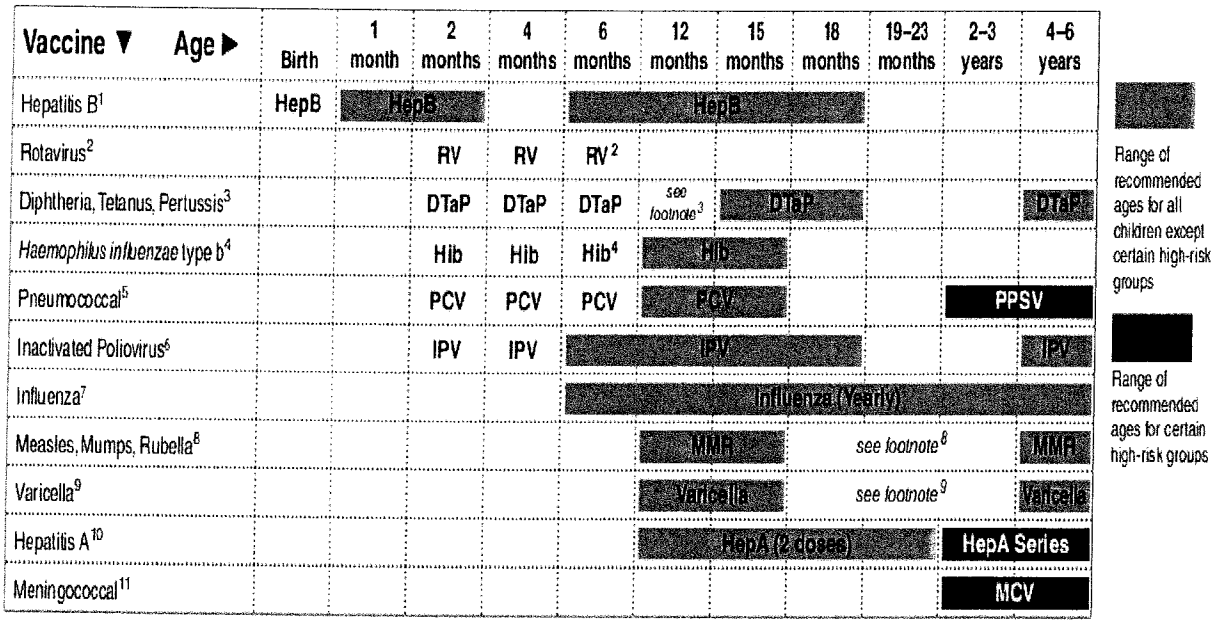
Table above is an excerpt from a CDC document found at:

http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf

Which of the vaccines mentioned in pages 5, 6, 7 and 8 are on the CDC recommended list of vaccines for children in the USA?

Recommended Immunization Schedule for Persons Aged 0 Through 6 Years—United States • 2010

For those who fall behind or start late, see the catch-up schedule



Aborted fetal cells and blood products:

At least one vaccine for the following diseases: chickenpox/varicella, diptheria, polio (IPV), tetanus and pertussis, Heamophilus influenzae type b (Hib), hepatitis A and B, measles, mumps, rubella and rotavirus are in one of the two lists above.

However, alternate products exist for some of these listed vaccines.

Ethical Alternatives:
Note: there are no vaccines from non aborted tissue cell line sources available in the USA for Rubella, Chickenpox, Shingles and Hepatitis A vaccines.

Does HB 227 make decisions for day care operators or parents? NO.
Children with medical exemptions are currently enrolled in day care and if HB 227 passes will continue to be enrolled in day care centers. Passing HB 227 will allow an increase in the number of exempted children in day care. Typically, medical exemptions account for approximately 1 child in 200 (.5 %).

HB 227 will increase choices for day care operators to accept a larger number of children as well as give parents of exempt children more choice in the availability of day care.

Does HB 227 make it more dangerous or a death sentence for children to attend day care? No.

- In the first place, unvaccinated does not mean un-immunized.
  Infectious diseases declined in both mortality and incidence by an average of 90% before either antibiotics or specific vaccines were developed. The great immunizers are sanitation and nutrition. Do not let vaccine proponents tell you that an unvaccinated child is un-immunized.

- Being unvaccinated does not mean that one carries a disease or will be exposing others to a disease. Additionally, it is expected that if a child, vaccinated or not, shows symptoms of disease the child will be kept home.

- Statistically, the greater number of vaccinated children in day care means that most of the disease incidence will be in the vaccinated.

- Individually, the percentage of children in day care who have measles infections will be 100 % if they are vaccinated with the current "attenuated LIVE MEASLES VIRUS" vaccine. According to the CDC "*Pinkbook*" all children who are susceptible to measles will develop a case of measles from the vaccine. So even if a day care had more unvaccinated children than vaccinated, the chances would still be greater that the vaccinated children will be the most likely source of exposure This truth is basically the same for not only measles but mumps, rubella and chickenpox.

Does HB 227 make it more dangerous or a death sentence for children to attend day care? No.

Vaccine proponents want people to believe that not vaccinating is dangerous, and even getting off the vaccine schedule is detrimental to children's health. These same proponents refuse to compare the health of totally unvaccinated children to children who receive all vaccines. Table 5 below shows the results of a study by BMC* which showed that children who delayed even one vaccination for medical reasons were actually healthier than children who remained on schedule. At least they were healthier at age 2, but by age 6 the benefit of delaying vaccinations had been lost and they were less healthy than their piers.

Table 5: Adjusted[a] odds ratios of health care utilization of children in the chart review

	Age 2 and under Group	
	Ever Refuse vs. Never Refuse	**Other significant[a] variables**
Any prescription use of select meds[b]	0.82 (0.47, 1.43)	HMO A, Up-to-date, With ear disorders or respiratory diagnoses.
Any Inpatient Use[b]	0.73 (0.44, 1.20)	HMO A, With respiratory, skin disorder, or seizure diagnoses.
Any ER Use[b]	0.81 (0.56, 1.15)	HMO A, Medicaid, With ear disorder, respiratory, skin disorder, or seizure diagnoses.
Total # of prescription use of specified med per person per enrollment day[d]	0.93 (0.80, 1.08)	Living in a white majority community, Up-to-date, With ear disorder, respiratory, skin disorder, or seizure diagnoses.
Total # of ER use per person per enrollment day[d]	**0.80 (0.64, 0.997)***	HMO B, Males, Living in a *non-white* majority community, With ear disorder, respiratory, skin disorder, or seizure diagnoses.
Total # of inpatient days per person[c]	**0.22 (0.09, 0.53)***	HMO B, *Not* up-to-date, *Without* ear disorder diagnosis, With respiratory, skin disorder, and seizure diagnoses.
Total # of outpatient visits per person per enrollment day[d]	**0.88 (0.79, 0.98)***	Living in a white majority community, With ear disorder, respiratory, skin disorder, or seizure diagnoses.
Total # of well-child visits per person per enrollment day[d]	1.05 (0.98, 1.12)	HMO A, *Without* ear disorder diagnoses.

Identification and Characteristics of vaccine refusers

BMC Pediatrics 5 March 2009

BMC = biomedcentral.com/1471-2431/9/18

"Table 5 also compared length of hospitalization, frequency of antibiotics, asthma, or seizure prescriptions, outpatients, well-child and emergency room visits between refusers and non-refusers, controlling for up-to date immunization status, HMO site, gender, Medicaid status, and select high use medical conditions. Although in the age 6 group, refusers and non-refusers were similar, refusers in the age 2 and under group had fewer hospital days per person (P-value = 0.0006), were less frequently seen in outpatient settings (P-value = 0.02) or emergency rooms (P-value = 0.047) than non-refusers."

Why have we requested elimination of the word "*notarized*" in HB 227?
We feel that the religious and medical exemptions should be harmonized. There is no requirement in the medical exemption to have a doctors signature notarized.

Why have we requested elimination of the phrase "*on a form prescribed by the department*" in HB 227?
The current form created by DPHHS are good quality forms. However, there is a trend across our nation to give parents a modification of a form created by American Academy of Pediatrics (AAP). The AAP form is basically a propaganda sheet about the alleged value of vaccines, the alleged risk of not vaccinating and most importantly, signing such a form could be considered a self incriminating form. Changing the law means that DPHHS can not require such a objectionable form but it in no way hampers the DPHHS in offering a form to parents for record keeping. However, changing the law would allow parents the choice of using a convenient form supplied by DPHHS or writing their own form. Obviously, as long as DPHHS offers a convenient and non-objectionable form, parents will use it.

Why have we requested addition of the phrase "in whole or in part" in HB 227?
This phrase harmonizes the religious exemption with the medical. It should be noted that some parents will object to one vaccine based on their religious convictions but not another vaccine. Vaccines that have material from continuous cell lines that originate in aborted fetal tissue are an example of vaccines are selectively opposed.

Why have we requested elimination of the sentence "*A person who falsely claims a religious exemption is subject to the penalty for false swearing provided in 45-7-202.*"?

Penalties for violation of 20-5-405 are covered in 20-5-410, MCA and cover the misuse of both the religious exemptions. Thus it is both discriminatory and unnecessary to have an additional and more severe penalty for violation of the religious exemption than the penalty for violation of the medical exemption.

Reference:

20-5-410. Civil penalty. (1) Any person who violates any provision of this part, any rule promulgated under this part, or any order made pursuant to this part, with the exception of 20-5-409 and any rule adopted or order issued pursuant to 20-5-409, is subject to a civil penalty not to exceed $500. The department or the local health department may institute and maintain any enforcement proceedings hereunder.

(2) Action under subsection (1) is not a bar to enforcement of this part or of rules or orders made under it by injunction or other appropriate civil remedies.

(3) An action for a civil remedy to enforce this part or rules or orders made under it may be brought in the district court of any county where a violation occurs or is threatened.

History: En. Sec. 9, Ch. 147, L. 1979.

DAYCARE AVAILABILITY TO RELIGIOUS EXEMPTION IN 48 OF 50 STATES

State	Medical	Religious/Per.	Type	Source
Alaska	Yes	Yes	Admin. Rule	Administrative Rules 7 AAC 57.550 Health
Alabama	Yes	Yes	Admin. Rule	Alabama Admin. Code r. 420-6-1-.03 (2006)
Arkansas	Yes	Yes	Statute	Statute Law 6-18-702(d) (4)
Arizona	Yes	Yes	Statute	Statute Law Title 36. Ch. 7.1. Article 1 A.R.S. § 36-883
California	Yes	Yes	Statute	Cal Health & Saf Code 105.2.1. § 120325 (2006)
Colorado	Yes	Yes	Statute	Statue C.R.S. 25-4-903. Exemptions from immunization
Connecticut	Yes	Yes	Statute	Conn. Gen. Stat. § Sec. 19a-79-6a. (d) (3) (E) (2006)
District of Columbia	Yes	Yes	Statute	Statute D.C. Code § 38-506 Exemption from certification.
Delaware	Yes	Yes	Admin. Rule	Administrative Code Title 14. 800. 5.1 & 14 Del.C. §131
Florida	Yes	Yes	Statute	Statute . § 1003.22 (5)
Georgia	Yes	Yes	Statute	Statute O.C.G.A. § 20-2-771 (c). & (e)
Hawaii	Yes	Yes	Statute	[HRS § 302A-1156]. Exemptions §302A-901. Specific definitions.
Iowa	Yes	Yes	Statute	Statute 139A.8.4 Immunization of children.
Idaho	Yes	Yes	Statute	Statute Idaho Code 39-1118
Illinois	Yes	Yes	Statute	Statute 225 ILCS 10/7 (2006) (h):
Indiana	Yes	Yes	Statute	Statute IC 12-17.2-3.5-11.1 (2007)
Kansas	Yes	Yes	Statute	Statute K.S.A. § 65-508 (2006)
Kentucky	Yes	Yes	Statute	Statute KRS § 214.036 (2007)
Louisiana	Yes	Yes	Statute	Statute La. R.S. 17:170 (2006) E.
Maine	Yes	Yes	Admin. Rule	Administrative Rules 10-148 CMR Chapter 32 A. 3.
Maryland	Yes	Yes	Statute	Statute Code 13A.14.02.44(3)(d)
Massachusetts	Yes	Yes	Admin. Rule	Administrative Regulations 102 CMR 7.09: (5) (a) 6.
Michigan	Yes	Yes	Admin. Rule	MICH. ADMIN. CODE R. 325.176 (2007)
Minnesota	Yes	Yes	Statute	Statute Minn. Stat. § 121A.15 (2007)Subdivision. 3.
Missouri	Yes	Yes	Statute	Statute Title 12. § 210.003- 2.(2)(b) R.S.Mo. (2006)
Mississippi	Yes	NO	Statute	Statute Miss. Code Ann. § 41-23-37 (2007)
Montana	Yes	NO.except Hib	Admin. Rule	Administrative Rules of Montana 37.95.140 IMMUNIZATION(13).
North Carolina	Yes	Yes	Statute	Statute N.C. Gen. Stat. § 130A-157 (2006)
North Dakota	Yes	Yes	Statute	Statute N.D. Cent. Code. § 23-07-17.1 (2006)
Nebraska	Yes	Yes	Statute	Statute R.R.S. Neb. § 71-1913.01 (2007)
New Hampshire	Yes	Yes	Statute	Statute Title X. RSA 141-C:20-c (2007)
New Jersey	Yes	Yes	Admin. Rule	Administrative Code: Ch. 14 NJ State Sanitary Code 8:57-4.4
New Mexico	Yes	Yes	Statute	Stat. Ann. § 24-5-2 (2007)
Nevada	Yes	Yes	Statute	Statute Title 38. NRS § 432A.230 (2007)
New York	Yes	Yes	Statute	Statute NY CLS Pub Health § 2164 (9)(2007)
Ohio	Yes	Yes	Admin. Rule	Administrative Code OAC 5101:2-12-37 (B) (2) (2007)
Oklahoma	Yes	Yes	Statute	Statute Title 10 Okl. St. § 413 (2007)
Oregon	Yes	Yes	Statute	Statute ORS 433.267 (2006)
Pennsylvania	Yes	Yes	Statute	Statute Title 28 Pa. Code. § 27.77 (2007)
Rhode Island	Yes	Yes	Admin. Rule	http://www2.sec.state.ri.us/dar/regdocs/released/pdf/DOH/5526.pdf
South Carolina	Yes	Yes	Admin. Rule	Administrative Rules (Law 44-29-180 states Reg. 61-8 applies)
South Dakota	Yes	Yes	Statute	Statute 13-28-7.1. (2)
Tennessee	Yes	Yes	Statute	Statute Tenn. Code Ann. § 49-6-5001 (c) (1) (2006)
Texas	Yes	Yes	Statute	Statute Title 2. § 42.043 (c) (2) (2007)
Utah	Yes	Yes	Statute	Code Ann. § 53A-11-301 (2007) Certificate
Virginia	Yes	Yes	Statute	Statute VCA § 22.1-271.2 C. (i) (2007)
Vermont	Yes	Yes	Statute	Statue Law Title 18: Chapter 21 § 1122.
Washington	Yes	Yes	Statute	Statute Rev. Code Wash. (ARCW) § 28A.210.080 &28A.210.090 (2007)
Wisconsin	Yes	Yes	Statute	Statute Wis. Stat. § 252.04 (2007)
West Virginia	Yes	Yes *	Admin. Rule	LEGISLATIVE RULES TITLE 78, SERIES 18 6.4.f.3. *(not in school)
Wyoming	Yes	Yes	Statute	Statute Wyo. Stat. § 21-4-309 (2007)

For easy checking see: **http://vaclib.org/legal/MTstate/daycare-urls.htm**
For 14 page document with law/rules excerpt, see:
http://vaclib.org/legal/MTstate/ReligiousExemptionLaws.pdf

Is material from aborted babies used in vaccine culture in the USA?

YES.

Below are the dates of abortions that provided material for developing "continuous cell lines" used to culture virus for vaccine production.

1962 July: The rubella virus in the MMR (measles, mumps, rubella) three-in-one shot is grown on the WI-38 cell line-developed in 1962 from an aborted three-month-old female fetus.
WI = Wistar Institute in Philadelphia, PA. 38 = 38th aborted baby.

1964: RA273 (R=rubella, A=abortus, 27=27th tissue tested, 3=3rd tissue explanted) also called RA/27/3. From this tissue a rubella virus was obtained that was cultured in the WI38 cell line.

1966, September: MRC-5 cell line derived from the normal lung tissue of a 14-week-old male fetus aborted "for psychiatric reasons."
(For more information, see: http://www.viromed.com/services/product/mrc5.htm)
MRC = Medical Research Council in England.

U.S. Produced Vaccines from Aborted Cell Lines :

Disease	Vaccine Name	Manufacturer	Cell line
Chickenpox/Varicella	(Varivax)	Merck & Co.	MRC-5
Diptheria DtaP-IPV/Hib	(Pentacel)	Sanofi Pasteur, Inc	MRC-5
Hepatitis A	(Havrix,)	Glaxo/SmithKline	MRC-5
Hepatitis A	(Vaqta)	Merck & Co.	MRC-5
HepA/HepB	(Twinrix)	Glaxo/SmithKline	MRC-5
Measles/Mumps/Rubella MMR	(MMR-II)	Merck & Co.	WI38 *
Measles/Mumps/Rubella/Varcella MMRV	(ProQuad)	Merck & Co.	MRC-5
Rabies	(Imovax)	Aventis-Pasteur	MRC-5
Shingles/Zoster	(Zostavax)	Merck & Co.	MRC-5

Reference: see the attached 4 sheets, *Vaccine Excipient & Media Summary, Part 2* from the Centers for Disease Control (CDC), except for the MMR * vaccine for which an excerpt from Merck's MMR-II package insert is printed on the last page following 3 paragraph from the *Vaccine Summary*.

Ethical Alternatives:
Note: there are no vaccines from non aborted tissue cell line sources available in the USA for Rubella, Chickenpox, Shingles and Hepatitis A vaccines.

Vaccine Excipient & Media Summary, Part 2

Excipients Included in U.S. Vaccines, by Vaccine

Includes vaccine ingredients (e.g., adjuvants and preservatives) as well as substances used during the manufacturing process, including vaccine-production media, that are removed from the final product and present only in trace quantities. In addition to the substances listed, most vaccines contain Sodium Chloride (table salt).

Vaccine	Contains
Anthrax (BioThrax)	Aluminum Hydroxide, Amino Acids, Benzethonium Chloride, Formaldehyde or Formalin, Inorganic Salts and Sugars, Vitamins
BCG (Tice)	Asparagine, Citric Acid, Lactose, Glycerin, Iron Ammonium Citrate, Magnesium Sulfate, Potassium Phosphate
DTaP (Daptacel)	Aluminum Phosphate, Ammonium Sulfate, Casamino Acid, Dimethyl-beta-cyclodextrin, Formaldehyde or Formalin, Glutaraldehyde, 2-Phenoxyethanol
DTaP (Infanrix)	Aluminum Hydroxide, Bovine Extract, Formaldehyde or Formalin, Glutaraldhyde, 2-Phenoxyethanol, Polysorbate 80
DTaP (Tripedia)	Aluminum Potassium Sulfate, Ammonium Sulfate, Bovine Extract, Formaldehyde or Formalin, Gelatin, Polysorbate 80, Sodium Phosphate, Thimerosal*
DTaP/Hib (TriHIBit)	Aluminum Potassium Sulfate, Ammonium Sulfate, Bovine Extract, Formaldehyde or Formalin, Gelatin, Polysorbate 80, Sucrose, Thimerosal*
DTaP-IPV (Kinrix)	Aluminum Hydroxide, Bovine Extract, Formaldehyde, Lactalbumin Hydrolysate, Monkey Kidney Tissue, Neomycin Sulfate, Polymyxin B, Polysorbate 80
DTaP-HepB-IPV (Pediarix)	Aluminum Hydroxide, Aluminum Phosphate, Bovine Protein, Lactalbumin Hydrolysate, Formaldehyde or Formalin, Glutaraldhyde, Monkey Kidney Tissue, Neomycin, 2-Phenoxyethanol, Polymyxin B, Polysorbate 80, Yeast Protein
DtaP-IPV/Hib (Pentacel)	Aluminum Phosphate, Bovine Serum Albumin, Formaldehyde, Glutaraldhyde, MRC-5 DNA and Cellular Protein, Neomycin, Polymyxin B Sulfate, Polysorbate 80, 2-Phenoxyethanol,
DT (sanofi)	Aluminum Potassium Sulfate, Bovine Extract, Formaldehyde or Formalin, Thimerosal (multi-dose) or Thimerosal* (single-dose)
DT (Massachusetts)	Aluminum Hydroxide, Formaldehyde or Formalin
Hib (ACTHib)	Ammonium Sulfate, Formaldehyde or Formalin, Sucrose
Hib (Hiberix)	Formaldehyde or Formalin, Lactose
Hib (PedvaxHib)	Aluminum Hydroxyphosphate Sulfate
Hib/Hep B (Comvax)	Amino Acids, Aluminum Hydroxyphosphate Sulfate, Dextrose, Formaldehyde or Formalin, Mineral Salts, Sodium Borate, Soy Peptone, Yeast Protein
Hep A (Havrix)	Aluminum Hydroxide, Amino Acids, Formaldehyde or Formalin, MRC-5 Cellular Protein, Neomycin Sulfate, 2-Phenoxyethanol, Phosphate Buffers, Polysorbate
Hep A (Vaqta)	Aluminum Hydroxyphosphate Sulfate, Bovine Albumin or Serum, DNA, Formaldehyde or Formalin, MRC-5 Cellular Protein, Sodium Borate
Hep B (Engerix-B)	Aluminum Hydroxide, Phosphate Buffers, Thimerosal*, Yeast Protein

Vaccine	Contains
Hep B (Recombivax)	Aluminum Hydroxyphosphate Sulfate, Amino Acids, Dextrose, Formaldehyde or Formalin, Mineral Salts, Potassium Aluminum Sulfate, Soy Peptone, Yeast Protein
HepA/HepB (Twinrix)	Aluminum Hydroxide, Aluminum Phosphate, Amino Acids, Dextrose, Formaldehyde or Formalin, Inorganic Salts, MRC-5 Cellular Protein, Neomycin Sulfate, 2-Phenoxyethanol, Phosphate Buffers, Polysorbate 20, Thimerosal*, Vitamins, Yeast Protein
Human Papillomavirus (HPV) (Cerverix)	3-*O*-desacyl-4'-monophosphoryl lipid A (MPL), Aluminum Hydroxide, Amino Acids, Insect Cell Protein, Mineral Salts, Sodium Dihydrogen Phosphate Dihydrate, Vitamins
Human Papillomavirus (HPV) (Gardasil)	Amino Acids, Amorphous Aluminum Hydroxyphosphate Sulfate, Carbohydrates, L-histidine, Mineral Salts, Polysorbate 80, Sodium Borate, Vitamins
Influenza (Afluria)	Beta-Propiolactone, Calcium Chloride, Neomycin, Ovalbumin, Polymyxin B, Potassium Chloride, Potassium Phosphate, Sodium Phosphate, Sodium Taurodeoxychoalate
Influenza (Agriflu)	Cetyltrimethylammonium Bromide (CTAB), Egg Protein, Formaldehyde or Formalin, Kanamycin, Neomycin Sulfate, Polysorbate 80
Influenza (Fluarix)	Egg Albumin (Ovalbumin), Egg Protein, Formaldehyde or Formalin, Gentamicin, Hydrocortisone, Octoxynol-10, α-Tocopheryl Hydrogen Succinate, Polysorbate 80, Sodium Deoxycholate, Sodium Phosphate, Thimerosal*
Influenza (Flulaval)	Egg Albumin (Ovalbumin), Egg Protein, Formaldehyde or Formalin, Sodium Deoxycholate, Phosphate Buffers, Thimerosal
Influenza (Fluvirin)	Beta-Propiolactone , Egg Protein, Neomycin, Polymyxin B, Polyoxyethylene 9-10 Nonyl Phenol (Triton N-101, Octoxynol 9), Thimerosal (multidose containers), Thimerosal* (single-dose syringes)
Influenza (Fluzone)	Egg Protein, Formaldehyde or Formalin, Gelatin, Octoxinol-9 (Triton X-100), Thimerosal (multidose containers)
Influenza (FluMist)	Chick Kidney Cells, Egg Protein, Gentamicin Sulfate, Monosodium Glutamate, Sucrose Phosphate Glutamate Buffer
IPV (Ipol)	Calf Serum Protein, Formaldehyde or Formalin, Monkey Kidney Tissue, Neomycin, 2-Phenoxyethanol, Polymyxin B, Streptomycin,
Japanese Encephalitis (JE-Vax)	Formaldehyde or Formalin, Gelatin, Mouse Serum Protein, Polysorbate 80, Thimerosal
Japanese Encephalitis (Ixiaro)	Aluminum Hydroxide, Bovine Serum Albumin, Formaldehyde, Protamine Sulfate, Sodium Metabisulphite
Meningococcal (Menactra)	Formaldehyde or Formalin, Phosphate Buffers
Meningococcal (Menomune)	Lactose, Thimerosal (10-dose vials only)
Meningococcal (Menveo)	Amino Acid, Formaldehyde or Formalin, Yeast
MMR (MMR-II)	Amino Acid, Bovine Albumin or Serum, Chick Embryo Fibroblasts, Human Serum Albumin, Gelatin, Glutamate, Neomycin, Phosphate Buffers, Sorbitol, Sucrose, Vitamins

Vaccine	Contains
MMRV (ProQuad)	Bovine Albumin or Serum, Gelatin, Human Serum Albumin, Monosodium L-glutamate, MRC-5 Cellular Protein, Neomycin, Sodium Phosphate Dibasic, Sodium Bicarbonate, Sorbitol, Sucrose, Potassium Phosphate Monobasic, Potassium Chloride, Potassium Phosphate Dibasic
Pneumococcal (Pneumovax)	Bovine Protein, Phenol
Pneumococcal (Prevnar)	Aluminum Phosphate, Amino Acid, Soy Peptone, Yeast Extract
Pneumococcal (Prevnar 13)	Aluminum Phosphate, Amino Acid, Polysorbate 80, Soy Peptone, Succinate Buffer, Yeast Extract
Rabies (Imovax)	Human Serum Albumin, Beta-Propiolactone, MRC-5 Cellular Protein, Neomycin, Phenol Red (Phenolsulfonphthalein), Vitamins
Rabies (RabAvert)	Amphotericin B, Beta-Propiolactone, Bovine Albumin or Serum, Chicken Protein, Chlortetracycline, Egg Albumin (Ovalbumin), Ethylenediamine-Tetraacetic Acid Sodium (EDTA), Neomycin, Potassium Glutamate
Rotavirus (RotaTeq)	Cell Culture Media, Fetal Bovine Serum, Sodium Citrate, Sodium Phosphate Monobasic Monohydrate, Sodium Hydroxide Sucrose, Polysorbate 80
Rotavirus (Rotarix)	Amino Acids, Calcium Carbonate, Calcium Chloride, D-glucose, Dextran, Ferric (III) Nitrate, L-cystine, L-tyrosine, Magnesium Sulfate, Phenol Red, Potassium Chloride, Sodium Hydrogenocarbonate, Sodium Phosphate, Sodium L-glutamine, Sodium Pyruvate, Sorbitol, Sucrose, Vitamins, Xanthan
Td (Decavac)	Aluminum Potassium Sulfate, Bovine Extract, Formaldehyde or Formalin, 2-Phenoxyethanol, Peptone, Thimerosal*
Td (Massachusetts)	Aluminum Hydroxide, Aluminum Phosphate, Formaldehyde or Formalin, Thimerosal (some multidose containers)
Tdap (Adacel)	Aluminum Phosphate, Formaldehyde or Formalin, Glutaraldehyde, 2-Phenoxyethanol
Tdap (Boostrix)	Aluminum Hydroxide, Bovine Extract, Formaldehyde or Formalin, Glutaraldehyde, Polysorbate 80
Typhoid (inactivated – Typhim Vi)	Disodium Phosphate, Monosodium Phosphate, Phenol, Polydimethylsilozone, Hexadecyltrimethylammonium Bromide
Typhoid (oral – Ty21a)	Amino Acids, Ascorbic Acid, Bovine Protein, Casein, Dextrose, Galactose, Gelatin, Lactose, Magnesium Stearate, Sucrose, Yeast Extract
Vaccinia (ACAM2000)	Glycerin, Human Serum Albumin, Mannitol, Monkey Kidney Cells, Neomycin, Phenol, Polymyxin B
Varicella (Varivax)	Bovine Albumin or Serum, Ethylenediamine-Tetraacetic Acid Sodium (EDTA), Gelatin, Monosodium L-Glutamate, MRC-5 DNA and Cellular Protein, Neomycin, Potassium Chloride, Potassium Phosphate Monobasic, Sodium Phosphate Monobasic, Sucrose
Yellow Fever (YF-Vax)	Egg Protein, Gelatin, Sorbitol
Zoster (Zostavax)	Bovine Calf Serum, Hydrolyzed Porcine Gelatin, Monosodium L-glutamate, MRC-5 DNA and Cellular Protein, Neomycin, Potassium Phosphate Monobasic, Potassium Chloride, Sodium Phosphate Dibasic, Sucrose

March 2010

*Where "thimerosal" is marked with an asterisk (*) it indicates that the product should be considered equivalent to thimerosal-free products. This vaccine may contain trace amounts (<0.3 mcg) of mercury left after post-production thimerosal removal, but these amounts have no biological effect. *JAMA* 1999;282(18) and *JAMA* 2000;283(16)

Adapted from Grabenstein JD. *ImmunoFacts: Vaccines & Immunologic Drugs*. St. Louis, MO: Wolters Kluwer Health Inc.; 2009 and individual products' package inserts.

All reasonable efforts have been made to ensure the accuracy of this information, but manufacturers may change product contents before that information is reflected here.

This document can be found on the CDC website at:

http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf

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Merck & CO., INC. Whitehouse Station, NJ 08889, USA **9912201**

M-M-R® II
(MEASLES, MUMPS, and
RUBELLA VIRUS VACCINE LIVE)

DESCRIPTION

M-M-R* II (Measles, Mumps, and Rubella Virus Vaccine Live) is a live virus vaccine for vaccination against measles (rubeola), mumps, and rubella (German measles).

M-M-R II is a sterile lyophilized preparation of (1) ATTENUVAX* (Measles Virus Vaccine Live), a more attenuated line of measles virus, derived from Enders' attenuated Edmonston strain and propagated in chick embryo cell culture; (2) MUMPSVAX* (Mumps Virus Vaccine Live), the Jeryl Lynn** (B level) strain of mumps virus propagated in chick embryo cell culture; and (3) MERUVAX* II (Rubella Virus Vaccine Live), **the Wistar RA 27/3 strain of live attenuated rubella virus propagated in WI-38 human diploid lung fibroblasts**.1,2

The growth medium for measles and mumps is Medium 199 (a buffered salt solution containing vitamins and amino acids and supplemented with fetal bovine serum) containing SPGA (sucrose, phosphate, glutamate, and recombinant human albumin) as stabilizer and neomycin.

The growth medium for rubella is Minimum Essential Medium (MEM) [a buffered salt solution containing vitamins and amino acids and supplemented with fetal bovine serum] containing recombinant human albumin and neomycin. Sorbitol and hydrolyzed gelatin stabilizer are added to the individual virus harvests.

The cells, virus pools, and fetal bovine serum are all screened for the absence of adventitious agents.

The reconstituted vaccine is for subcutaneous administration. Each 0.5 mL dose contains not less than 1,000 TCID50 (tissue culture infectious doses) of measles virus; 12,500 TCID50 of mumps virus; and 1,000 TCID50 of rubella virus. Each dose of the vaccine is calculated to contain sorbitol (14.5 mg), sodium phosphate, sucrose (1.9 mg), sodium chloride, hydrolyzed gelatin (14.5 mg), recombinant human albumin (≤0.3 mg), fetal bovine serum (<1 ppm), other buffer and media ingredients and approximately 25 mcg of neomycin. The product contains no preservative.

Before reconstitution, the lyophilized vaccine is a light yellow compact crystalline plug. M-M-R II, when reconstituted as directed, is clear yellow.

[Issued March 2010]

Excerpt above is from the Package Insert found at:
http://www.merck.com/product/usa/pi_circulars/m/mmr_ii/mmr_ii_pi.pdf

MMR Vaccine

The first measles vaccines were introduced in 1963. One of the two vaccines was removed from the market due to the fact that it increased the number of measles cases. The combined measles, mumps and rubella vaccine, the MMR, was put on the market in 1971.

The following quote is from the CDC's measles chapter of the "Pink Book":

Adverse reactions following measles vaccine (except allergic reactions) represent replication of measles vaccine virus with subsequent mild illness. These events occur 5–12 days post vaccination and only in persons who are susceptible to infection. There is no evidence of increased risk of adverse reactions following MMR vaccination in persons who are already immune to the diseases.

MMR Adverse Reactions

• Fever	5%-15%
• Rash	5%
• Joint symptoms	25%
• Thrombocytopenia	<1/30,000 doses
• Parotitis	rare
• Deafness	rare
• Encephalopathy	<1/1,000,000 doses

Fever is the most common adverse reaction following MMR vaccination. Although measles, rubella, and mumps vaccines may cause fever after vaccination, the measles component of MMR vaccine is most often associated with this adverse reaction. After MMR vaccination, 5%–15% of susceptible persons develop a temperature of 103 F (39.4 C) or higher, usually occurring 7–12 days after vaccination and generally lasting 1–2 days. Most persons with fever are otherwise asymptomatic.

The measles chapter of the "pink book" can be found on the CDC website at:
http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/meas.pdf

The MMR is a live measles virus (attenuated) vaccine. (It also has mumps and rubella components that we are not concerned with here.) Not included in the above graphic is that 2.1 % of the children have a "measles like rash" as distinguished from 5% generalized rash.

So what does 15% fever, 5% rash of which 2.1 % is a "measles like rash" occurring within 5-12 days after MMR vaccination translate too?

About 4 million children are born per year and about 99% of them receive 2 doses of MMR before age six.

4,000,000 x 2 vaccinations x .99 =	7.92 million measles infections per year.
4,000,000 x .15 x .99 =	594,000 measles related fevers after first vaccination,
4,000,000 x .05 x .99 =	198,000 measles related fevers after first vaccination. (estimated)

Or

4,000,000 x .05 x .99 =	198,000 cases of rash after the MMR vaccination.

Or

4,000,000 x .021 = 84,000 cases of measles like rash, + an estimated 28,000 more children following the second dose of MMR with a measles like rash for a total of 112,000 measles cases of measles.

Measles - USA

Pre-sanitation/Pre-nutrition Era

- 95-100 % of children had measles between age 1 and age 15.
- From 1920-1929, the average measles reports per year = 467,000
- Average number of births per year was in the vicinity of two million. (1900)
- Death rate in 1900 associated with measles was about one death per 250 live births.
- Number of deaths associated with measles was over 8,000 per year between 1900-1909.

Pre-vaccine Era

- 10 to 50 % of children experienced measles. *
- From 1959-1962: 440,000 measles were reported per year.
- Average number of births per year was in the vicinity of four million.
- Number of deaths quoted by CDC is 450 deaths per year. (From 1959-1962: only 404 deaths per year.)
- Death rate circa 1960 was about 1 child per 10,000 life births. (4,000,000/400 = 10,000) (98% decline.)
- Death rate circa 1960 was about 1 child per 1,000 REPORTED cases. **

*Vaccine proponents often make the false claim that 100% children had measles in the pre-vaccine era. The figure of 100 % is not correct as shown by the fact that 440,000 reports equates to at most 2.2 million cases with common estimates being 2 million. However, 2 million is only 50 % of 4 million. During 1946 to 1964 the USA had "baby boom" years with a maximum of 4.2 million children born.

**If 1 child died for each 1,000 cases, then 450 deaths x 1,000 = 450,000 cases per year. Given that reports ranged from 200 to 600 thousand, an average number of 400,000 cases per year would be a reasonable lower limit to the estimated yearly average number of measles cases. In other words, 400,000 is 10 % of 4 million.

Conclusions:

Measles associated mortality declined by 98 percent prior to the introduction of a measles vaccine.

Measles incidence declined from nearly 100 percent of children to less than 50 percent of children and may have been as lower.

(Over)

Vaccination is Not the will of the Majority

Proponents of mandatory vaccination often cite the idea that vaccination is the will of the majority. However, this is not so. Take a brief look at history.

1800's England
Vaccination was introduced about 1800 and was made mandatory in England in 1853 because the majority of people believed the practice to be ineffective and dangerous. In some areas as much as 90 percent of the population avoided vaccination. In fact, after suffering greatly in a smallpox epidemic the city of Leicester rejected vaccination in favor of sanitation. Only 5% of the children in the next two decades were vaccinated. This constituted a 95% rejection of vaccination. Leicester became the city with the least number of smallpox cases in England. Note: prior to the 1872 smallpox epidemic, Leicester was approximately 97.5 percent vaccinated.

USA
Circa 1920 a pro-vaccine medical doctor stated that with education about 28 percent of the people would accept vaccination. With fear and pressure the remaining 72 percent would accept vaccination.

USA
Coming closer to our own time, the Influenza Vaccination (flu) was licensed in 1945.
In 1980, after 35 years use, acceptance was only 20 percent of the target population.
In 1988, after 43 years of use the coverage was only 33 percent.
By the year 2000, coverage of the target population was about 65 percent.
It took over 50 years of voluntary flu vaccine use to reach the majority, over 50 percent, of the target population, those over age 65.

Reference: October 2001 anthrax was sent through the mail:
USA January 2002

"Of 10,000 people who may have been exposed to anthrax during the recent attacks, **fewer than 2 percent** have taken the anthrax vaccine, a figure that reflects postal employees' deep reluctance to enroll in a medical experiment, federal health officials said today."
Published by The New York Times, January 8, 2002.

The majority of people are perfectly willing to "wait and see" if effectiveness and safety is established before adopting the use of a vaccine.

Mandatory vaccination is the will of a minority which is imposed upon the majority.

Summary of Natural Immunity in the unvaccinated

Hepatitis B: Disease incidence was less than 6 per 100,000 for individuals less than 19 years of age prior to recommendation of Infant Vaccination in 1992.

Rotavirus: Placebo-controlled trials by Merck show over 90% natural immunity in the placebo group for the first rotavirus season following vaccination.

Diphtheria: There was a 95 percent decline in mortality due to diphtheria prior to using diphtheria vaccine according to the records of the Metropolitan Life Insurance Co. Today natural immunity in unvaccinated children is above 99%.

Tetanus is not contagious. Incidence had dropped to about 1 case per 250,000 population per year prior to tetanus incidence being officially counted and tracked by public health officials and prior to widespread civilian use of tetanus vaccine.

Pertussis: Natural immunity in unvaccinated children is at least 85 percent and authorities are beginning to question if pertussis is a vaccine preventable disease.

Hib: In the prevaccine era (mid-1980s), every child was exposed to Hib bacteria but 99.5 percent never experienced symptoms.

Pneumococcal disease: Lifetime natural immunity in 1999, before the introduction of a vaccine was greater than 95%.

Polio: In the Netherlands, a group numbering about 183,400 unvaccinated in a subpopulation of 275,000 had a polio incidence rate between 1978 and 1993 of 11 cases per year. 110 cases occurred in 1978, thus there was no polio incidence in 14 of the 16 years of the study. (99.9999% immunity.)

Influenza: Children have higher rates of influenza than do adults but influenza vaccines have come under attack for low to non existent effectiveness rates.

Measles: In 1900, natural immunity was less than 5 percent, by 1960 natural immunity had risen to greater than 50 percent and may be as high as 99 percent today.

Mumps: A disease with the highest rates among children over 5 years of age. The natural immunity to mumps in 1967, prior to the licensure of mumps vaccine was over 80* percent and is higher today. (*Estimated, based on 1 in 5 under-reporting.)

Rubella: a very mild illness. At one point the American Medical Association Journal reported that more than 90% of the obstetricians and gynaecologists had refused vaccination even though their patients are at high risk for Rubella occurring in pregnancy. Results of a vaccine trial by Merck, the pharmaceutical giant, suggests that natural immunity to rubella is above 98 percent.

Hepatitis A: According to the CDC, the prevaccine Hepatitis A incidence ranged from 9 to 15 cases per 100,000 population.

Meningococcal disease: In the USA, 1400 to 2800 total cases per year equates to greater than 99 percent natural immunity.

Varicella/chickenpox declined in incidence as much as 83 percent prior to introduction of a vaccine, thus natural immunity exists and has improved since.

Mortality declined for children due to improved Sanitation and Nutrition

- Measles mortality declined by 98 % before an introduction of measles vaccine in the United States.
- Measles mortality declined by 99.4 % before an introduction of measles vaccine in England and Wales. Similar declines in measles mortality were noted in Australia.

- Tuberculosis mortality declined in the United States with out wide spread use of a vaccine.

- Scarlet Fever mortality declined in the United States **with out any use of a vaccine**.

- Scurvy mortality is admittedly a nutritional problem, yet in England and Wales, Scurvy associated mortality declined simultaneously with measles and pertussis mortality.

- According to the CDC, "The incidence of typhoid fever declined steadily in the United States from 1900 to 1960 and has since remained at a low level." These low levels of typhoid fever have occurred without widespread use of typhoid vaccine.
  [Source: http://www.cdc.gov/mmwr/preview/mmwrhtml/00001710.htm]

- Australia had similar declines in typhoid fever mortality from 1910 to 1970 with no widespread vaccination.

Among the following, which if any, are responsible for the death of children?

- **Virulent "Bugs",** [The "weak-bugs versus strong (virulent) bugs theory.]
- **Malnutrition**, **[Does adequate nutrition protect a child during both health and disease?]**
- **Lack of Vaccination**, [Can malnourished children be "immunized" by vaccinating?]

The **"weak-bug strong-bug" theory** arose due to the observation that some children die with a disease that for many other children is a relatively minor experience. Research with vitamins as well as the epidemiological trends prove that children die of malnourishment and not from virulent virus. See the attached graphs.

Malnutrition, not strong bugs, causes the death of children. As an example, "There is a "cure" for measles. It is called vitamin A... cod-liver oil. As early as 1932 doctors used cod-liver oil to reduce hospital mortality by 58%, but then antibiotics became the treatment of fashion, (Clin. Infect. Dis., Sept. 1994, pg 493) and vitamin A was ignored until 1980. A 1993 study showed that 72% of hospitalized measles cases in America are vitamin A deficient, and the worse the deficiency the worse the complications and higher the death rate. (Pediatric Nursing, Sept./Oct. 96.)" Quoted from: http://www.ias.org.nz/measles.htm
The principle that nutrition saves lives applies to all the diseases of childhood.

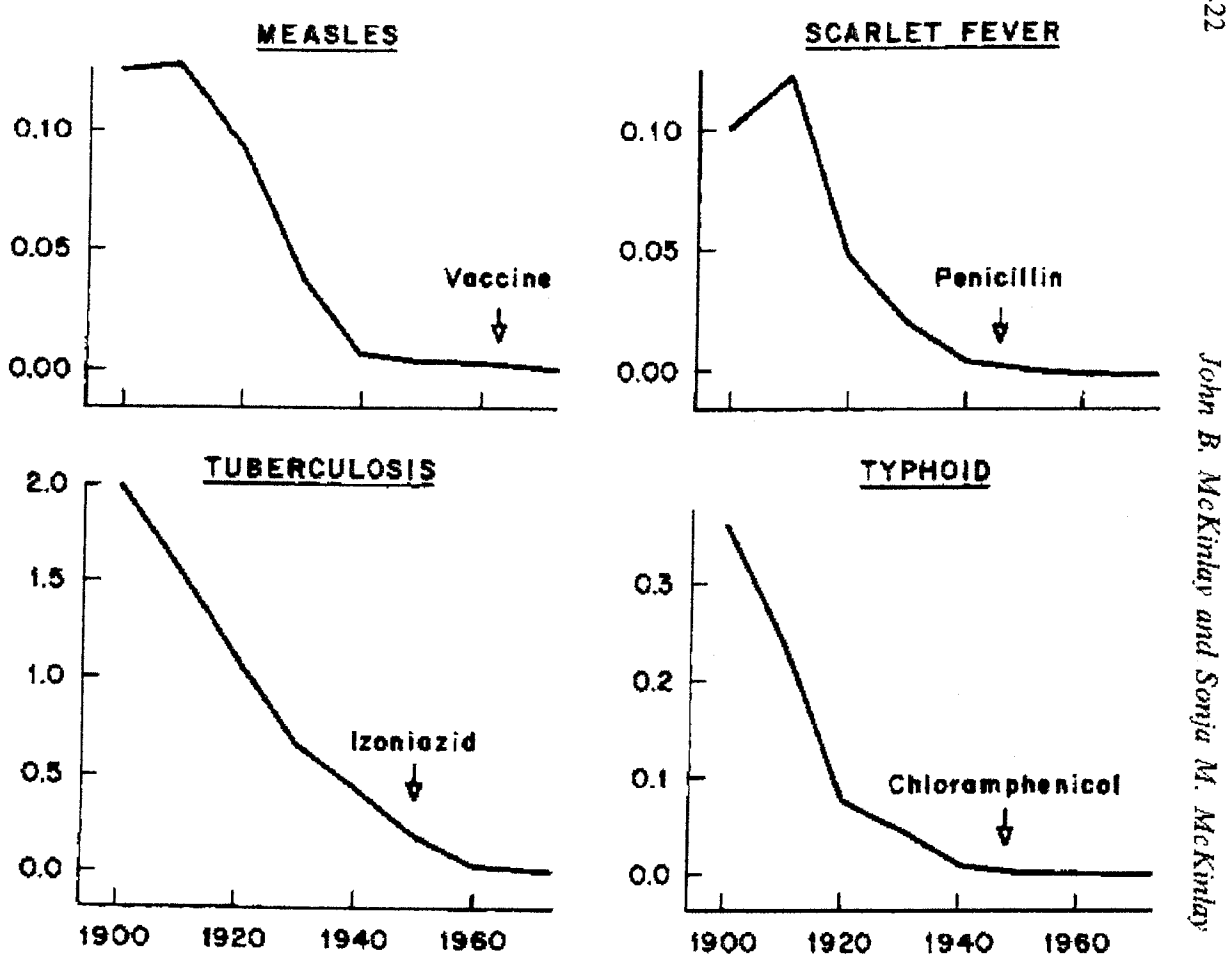
Malnourished children can not be "immunized" with vaccines. When large numbers of malnourished children are vaccinated, death rates go up, sometimes in a dramatic fashion. This has been proved in Africa and even more notably in Australia where vaccinated aborigines experienced their death rate double and in the worst case example some districts saw their death rate go up to 500 per 1000 (1 in 2) children. Vitamin C injections before and after vaccination reduced the death rate to nearly zero. In England and Wales, death rates from scurvy paralleled the death rates from measles and pertussis; death rates from each of these three diseases declined simultaneously.

Sanitation saves lives by preventing the cause for many diseases. Year around nutrition saves lives by providing the necessary elements for children to maintain health and recover quickly and safely when disease occurs. Vaccination can change the words inserted in the "Cause of Death" column on a death certificate but no evidence exists to prove that vaccines have ever lowered overall death rates in any population.

The Questionable Contribution of Medical Measures to the Decline of Mortality in the United States in the Twentieth Century

by John B. McKinlay; Sonja M. McKinlay

The Milbank Memorial Fund Quarterly. Health and Society, Vol. 55, No. 3. (Summer, 1977), pp. 405-428. [Source: http://www.jstor.org/pss/3349539 ©Milbank Memorial Fund 1977]



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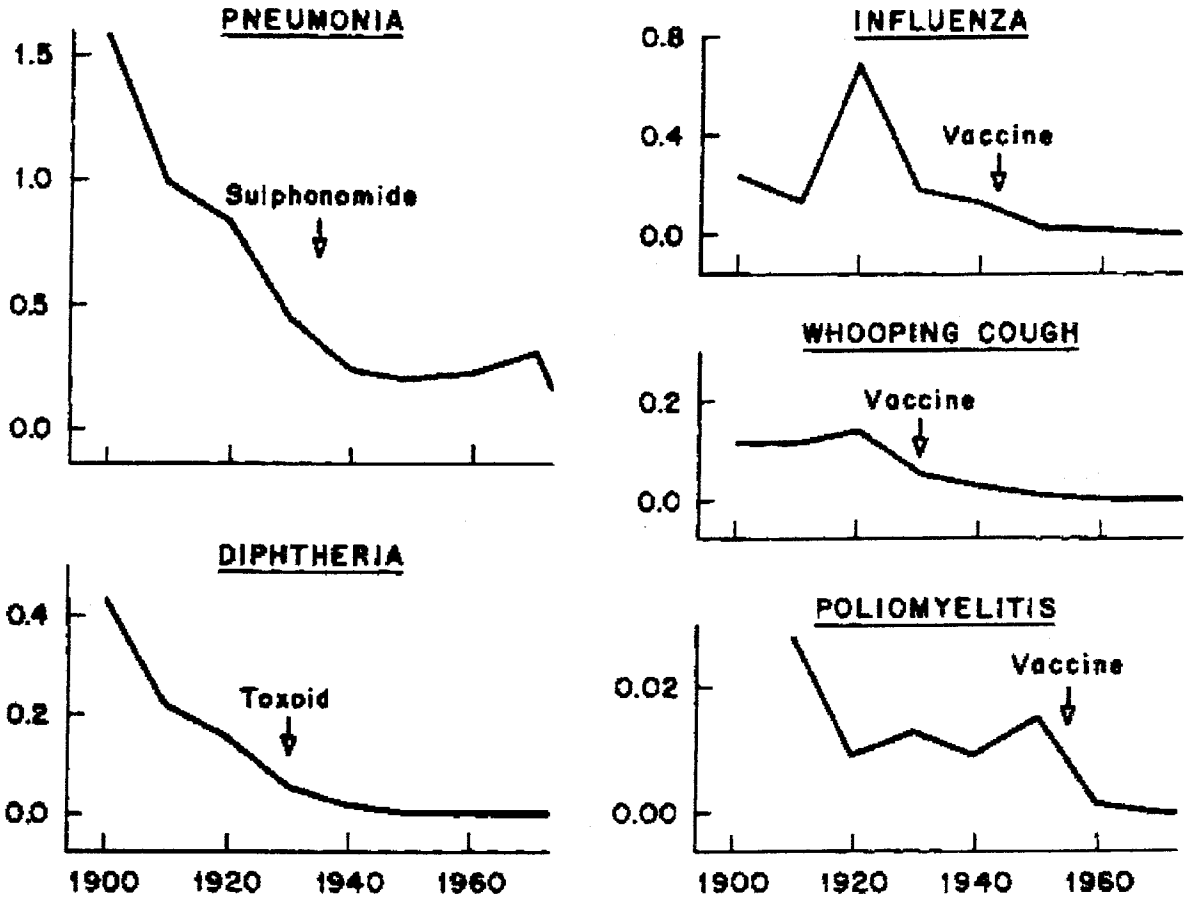


FIG. 4. The Fall in the Standardized Death Rate (per 1,000 Population) for Nine Common Infectious Diseases in Relation to Specific Medical Measures, for the United States, 1900–1973.

Conclusions

Without claiming they are definitive findings, and eschewing pretentions to an analysis as sophisticated as McKeown's for England and Wales, one can reasonably draw the following conclusions from the analysis presented in this paper:

In general, medical measures (both chemotherapeutic and prophylactic) appear to have contributed little to the overall decline in mortality in the United States since about 1900- having in many instances been introduced several decades after a marked decline had already set in and having no detectable influence in most instances. More specifically, with reference to those five conditions

(influenza, pneumonia, diphtheria, whooping cough, and poliomyelitis) for which the decline in mortality appears substantial after the point of intervention-and on the unlikely assumption that all of

this decline is attributable to the intervention-it is estimated that at most 3.5 percent of the total decline in mortality since 1900 could be ascribed to medical measures introduced for the diseases considered here. [page 425 ©Milbank Memorial Fund 1977]

Estimated Vaccination Coverage for Montana Children - Year 2009

This page consists of excerpts from:
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5936a2.htm?s_cid=mm5936a2_w

Morbidity and Mortality Weekly Report (MMWR)
National, State, and Local Area Vaccination Coverage Among Children Aged 19--35 Months --- United States, 2009

> To estimate coverage for all age-eligible children, NIS uses a quarterly, random-digit--dialed sample of telephone numbers for the 50 states and selected urban areas and territories,* followed by a mail survey of the children's vaccination providers to collect vaccination information. Data were weighted to represent the population of children aged 19--35 months, with adjustments for households with multiple telephone lines, household nonresponse, and exclusion of households without landline telephones.† During 2009, the household response rate§ was 63.9%; a total of 17,313 children with provider-reported vaccination records were included in this report, representing 70.7% of all children with completed household interviews.

Editorial Comment:
17,313 children **nationwide** means that Montana, with about 1 million population in a country of 300 million, had about 17,313 ÷ 300 or **somewhere in the vicinity of 58 Montana children were included in the survey by their vaccine providers from a total of about 82 Montana children included in household telephone surveys.**

TABLE 2. Estimated vaccination coverage for vaccination series (modified)* and selected individual vaccines among children aged 19--35 months, by state and local area --- National Immunization Survey, United States, 2009†

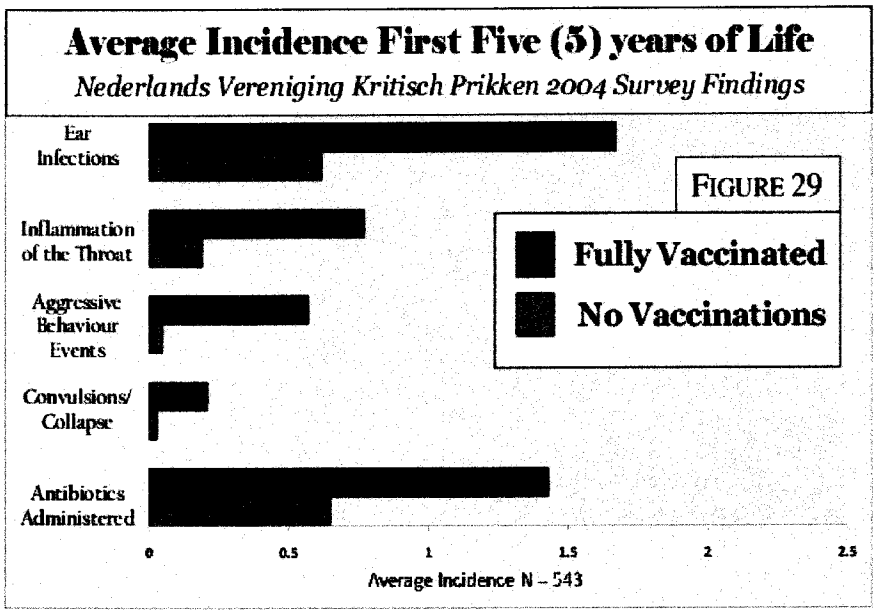
	MMR (≥1 doses)		PCV (≥4 doses)		Hep B (birth)§		HepA (≥2 doses)¶		Rotavirus**		Vaccine series (modified)	
State/Area	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)
United States	90.0	(±0.8)	80.4	(±1.1)	60.8	(±1.3)	46.6	(±1.4)	43.9	(±1.4)	70.5	(±1.2)
Montana	87.2	(±5.0)	74.6	(±6.7)	65.2	(±7.2)	31.1	(±7.0)	30.7	(±6.8)	61.7	(±7.5)

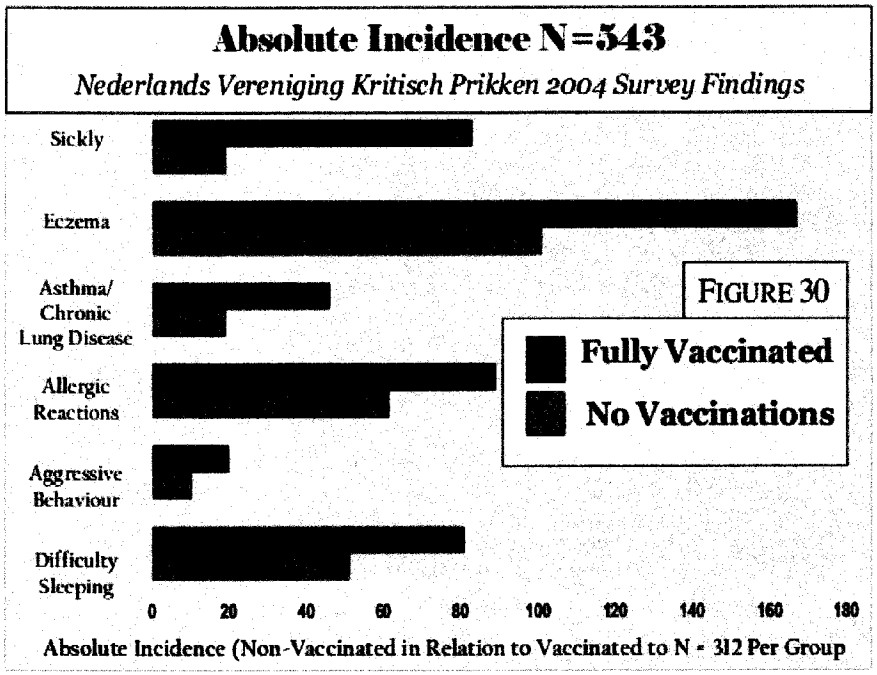
Editorial comment:
It should also be noted that nationwide, the percentage of grade 1-12 children who receive all the "recommended" vaccinations is about 99 percent. Montana does not differ markedly from the national average of 99 percent vaccinated school aged children.

The two graphs below are from page 28 of:

Immunization Graphs:
Natural Infectious Disease Declines; Immunization Effectiveness; and Immunization Dangers

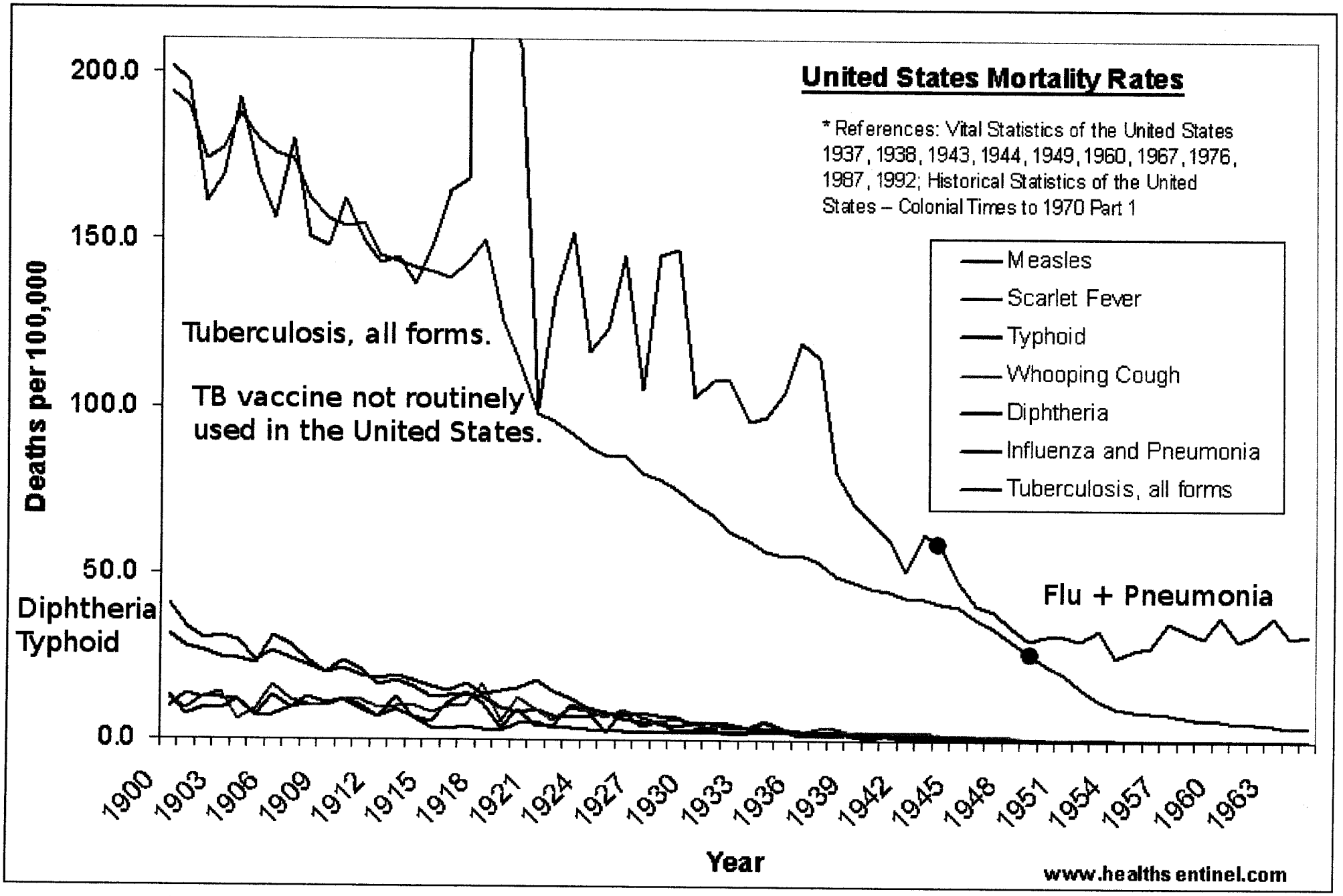
Prepared by: Raymond Obomsawin Ph.D.
Senior Advisor – First Nations Centre
National Aboriginal Health Organization
October 2009





[Dr. Obomsawin holds an M.Sc. and a PhD with concentrations in health science and human ecology. He currently heads his own research consulting service in eastern Canada. He has previously served as Senior Advisor on First Nations Health at the National Aboriginal Health Organization; Executive Director in the California Rural Indian Health Board system; Director of the Office for National Health Development NIB (now Assembly of First Nations); and founding Chairman of the National Commission Inquiry on Indian Health. His international work included appointments as Manager of Overseas Operations for CUSO; Evaluation Analyst and later Senior Advisor on Indigenous Knowledge at the Canadian International Development Agency.

Dr. Obomsawin has advised senior decision-makers in the public sector regarding varied health, education, agriculture, nutrition, agro-forestry, and environmental projects. He Co-Chaired the United Nations Environment Program – Convention on Biological Diversity (CBD) Ad Hoc Technical Expert Group on the Potential Impacts of Genetic Use Restriction Technologies (alias "Terminator Seed" technologies).
[Biographical information is from http://www.whale.to/vaccines/obomsawin_h.html]


United States Mortality Rates
* References: Vital Statistics of the United States 1937, 1938, 1943, 1944, 1949, 1960, 1967, 1976, 1987, 1992; Historical Statistics of the United States – Colonial Times to 1970 Part 1
Measles
Scarlet Fever
Typhoid
Whooping Cough
Diphtheria
Influenza and Pneumonia
Tuberculosis, all forms
Tuberculosis, all forms.
TB vaccine not routinely used in the United States.
Flu + Pneumonia
Diphtheria
Typhoid
Deaths per 100,000
200.0
150.0
100.0
50.0
0.0
1900
1903
1906
1909
1912
1915
1918
1921
1924
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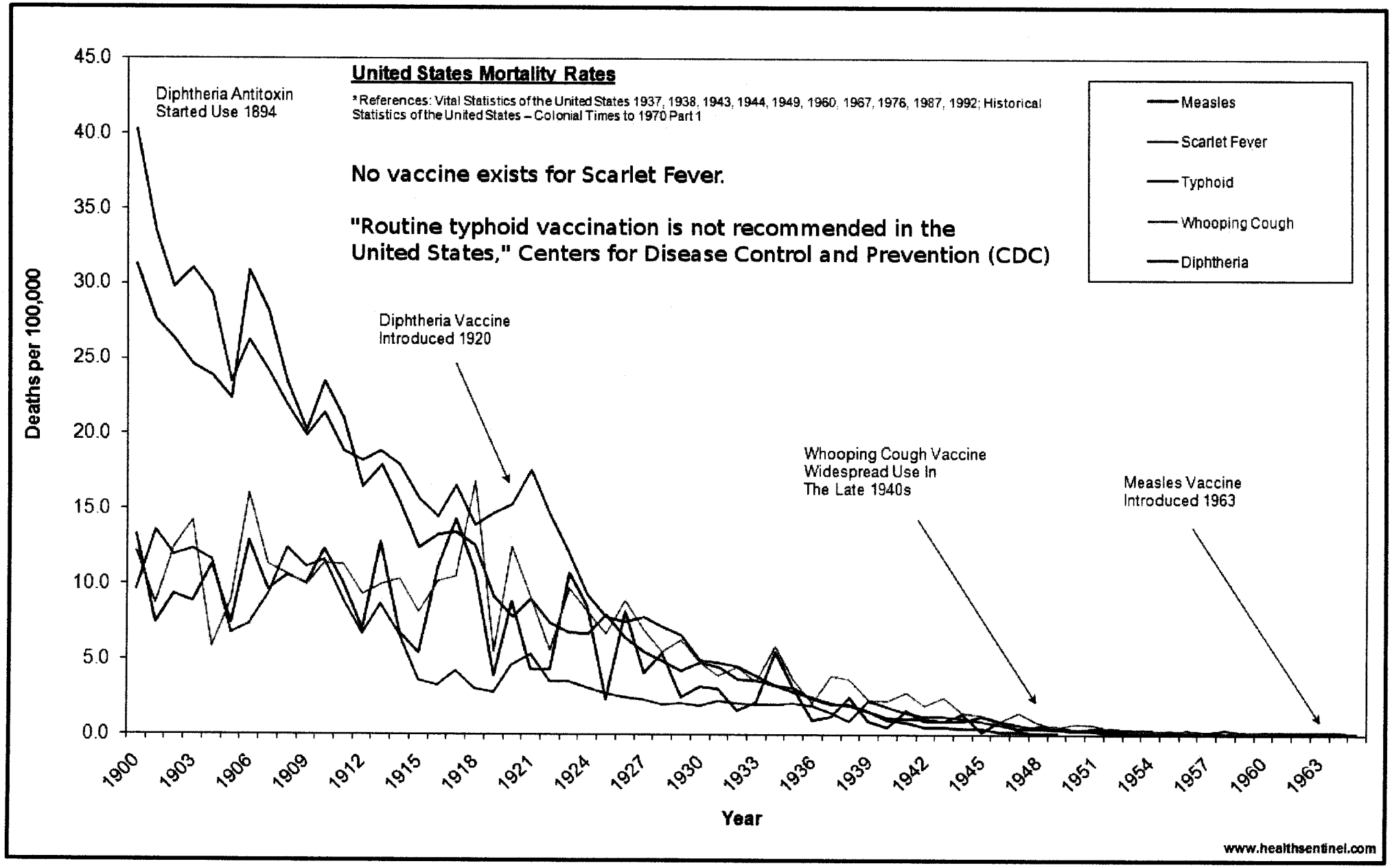
Year
www.healthsentinel.com


United States Mortality Rates
*References: Vital Statistics of the United States 1937, 1938, 1943, 1944, 1949, 1960, 1967, 1976, 1987, 1992; Historical Statistics of the United States – Colonial Times to 1970 Part 1
Diphtheria Antitoxin Started Use 1894
No vaccine exists for Scarlet Fever.
"Routine typhoid vaccination is not recommended in the United States," Centers for Disease Control and Prevention (CDC)
Measles
Scarlet Fever
Typhoid
Whooping Cough
Diphtheria
Diphtheria Vaccine Introduced 1920
Whooping Cough Vaccine Widespread Use In The Late 1940s
Measles Vaccine Introduced 1963
Deaths per 100,000
45.0
40.0
35.0
30.0
25.0
20.0
15.0
10.0
5.0
0.0
1900
1903
1906
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www.healthsentinel.com

Dr. Sherri Tenpenny, D.O.

OUTBREAKS PROOF THAT WHOOPING COUGH VACCINES DON'T WORK

Dr. Sherri Tenpenny, DO
January 11, 2011
NewsWithViews.com

This past summer, newspapers throughout North America announced an epidemic of whooping cough, caused by the bacterium Bordetella pertussis, in California that health officials predicted would spread throughout the country. From January, 2010 through the end of November, California's state epidemiologist reported 2,625 pertussis cases including ten infant deaths while the Center for Disease Control and Prevention (CDC) reported 18,586 cases nationwide. [1] The reports have speculated that the outbreaks have been caused by the large number of unvaccinated children throughout the state. What these reports fail to mention is that most of the children who contracted pertussis had been vaccinated against whooping cough.

In response to the outbreaks, the California state legislature passed a law in September, 2010. The new law targets children in 7th to 12th. Starting with the 2012-13 school year, parents have been told that incoming seventh graders will need to provide proof of vaccination. [2] This has lead to some confusion because California law allows the execution of personal belief exemptions, or PBEs, giving parents the right to refuse vaccines.[3] According to 2009 records, close to 175 schools had PBE rates of 20 percent or more. A few schools had exemption rates above 70 percent. [4] While that may seem alarming to some, officials estimate that the overall rate for PBEs among the state's roughly 7,200 schools is about 2 percent. Officials believe that vaccination rates of at least 93 percent are needed to ensure so-called herd immunity against pertussis. So with 98 percent of California's children receiving all of the CDC recommended vaccines, herd immunity should be maintained and blaming the unvaccinated for the outbreak is not logical.

Vaccine failures

The push for children of all ages and even their adult family members to get their DTaP shot is certainly questionable when one looks at a sampling of the well-documented cases of vaccine failure in communities with large numbers of whooping cough cases. In 1996, a statewide outbreak of pertussis occurred in Vermont, a state where vaccination rates were among the highest in the country. Of those children, 19 to 35 months of age who contracted whooping cough, 97 percent had received all doses of the recommended DTaP vaccines.

In 2006, British Medical Journal reported on a study showing that a substantial proportion of immunized children of school age who have a persistent cough may have had a recent infection with Bordetella pertussis. Harnden and colleagues recruited 172 children aged 5 to 16 years (from 18 U.K. general practices) who had been coughing for two weeks or more.

Serological evidence of a recent pertussis infection was found in 64 of the children, and 55 of these children had been fully vaccinated. They went on to say, "Making a secure diagnosis of whooping cough may reassure the parents and prevent inappropriate investigations and treatment, conclude the authors." [5]

More recently, *The Star-Ledger* reported on February 11, 2009 of a pertussis outbreak in 21 fully vaccinated children in Hunterdon County, New Jersey. [6] Even in Canada, a laboratory-confirmed pertussis outbreak occurred among preschool children in Toronto where greater than 90 percent of the kids were up-to-date with pertussis immunization. [7]

The Watchdog Institute, an investigative journalism center based in San Diego, recently teamed up with local San Diego television station, KPBS, to research the actual number of families affected by the whooping cough outbreak to determine how many children had been fully vaccinated against pertussis. The four-month investigation culminated in the airing of a documentary on December 16, 2010. Their research was revealing: In the nine California counties most affected, 44 to 83 percent of those contracting the infection had been fully vaccinated. In Ohio and Texas, two states also having record numbers of whooping cough cases, 75 and 67.5 percent respectively had been vaccinated. [8]

Dr. Fritz Mooi, a respected Dutch scientist who has been studying pertussis bacteria mutations for 15 years, claims a more virulent strain is the cause of recent outbreaks. Mooi says the international Global Pertussis Initiative has ignored his theories about a new, more toxic strain of the disease. "They just don't want to listen," he said. "They have kept it out of their articles, and it's a kind of censorship." Much money has been invested in the current vaccine, Mooi said, and if he is right about a new strain, a different vaccine would need to be developed. [9]

Conflicts of interest

The Watchdog Institute and KPBS further found that the two leading global makers of pertussis vaccines, Sanofi Pasteur and GlaxoSmith Kline, have funded expert groups that recommend vaccine policy on the disease to government agencies. Sanofi Pasteur funds the most influential group, the Global Pertussis Initiative, which is made up of 35 medical experts from 16 countries. The Watchdog Institute and KPBS found that 24 of the group's members have received funding from Sanofi Pasteur, its parent company Sanofi-Aventis, and/or GlaxoSmithKline (GSK). [10]

The CDC cites the Global Pertussis Initiative in its publications and the World Health Organization had four members of the Initiative on their pertussis vaccine advisory committee. This conflict of interest translates to countries spending millions on pertussis vaccines that have a long history of not being protective, with the manufacturers unwilling to spend any of their revenue on research into emerging strains of pertussis. Globally, vaccines were a $22 billion industry last year and according to one forecast, sales are expected to top $34 billion by 2012. In just the state of California, health departments spent $207 million on pertussis vaccines since 2007 with a whopping $59.6 million spent in 2010. [11]

Vaccinated as Silent Carriers

Vaccine-induced immunity to pertussis is measured by a blood test, called a titer test, which measures the presence of specific antibodies thought to be protective. It is recognized that these antibodies wane over time. The incidence of B. *pertussis* infection in adolescents and adults appears to be approximately one percent per year. Infection is most likely to be pertussis among those with a cough that has lasted more than 21 days. Officials believe infections in adolescents caused by "waning immunity" to be a source of transmission in the

community, particularly for young infants.

As a result, new vaccines such as Boostrix, for children 11 to 18 years of age, and Adacel, for adults 19 to 64 years of age, have been developed and licensed for use in the U.S. [12] Public health officials hope that by vaccinating teens and adults there will be fewer cases of pertussis overall. The rush to revaccinate the entire population and all age groups against pertussis has had little effect on lowering the incidence of whooping cough overall.

Pertussis-containing vaccines seem to have little effect on the overall incidence of the infection. Instead of focusing on the fear of whooping cough, it is obvious we need to focus on strengthening the immune system naturally and simple public health measure that work. Health aids such as hand washing, getting eight hours of sleep per night, taking vitamin C and maintaining a high blood level of Vitamin D are foundational in the prevention of all infectious diseases, including pertussis. Clearly, public health officials need to embrace these non-toxic, non-invasive methods over injections that don't work and can cause serious harm.

Footnotes:

1, MMWR. Pertussis Weekly Update. Week 48
2, "New California Law Mandates Whooping Cough Booster Shot for Teens," Jan 3, 2011.
3, National Vaccine Information Center documentation.
4, Whooping Cough in California Worries Officials. ABC Healthnews. June 24, 2010.
5, Ibid
6, "Whooping Cough returns to Hunterdon County" by Mike Frasinelli, The Star-Ledger, February 11, 2009 .
7, Waters, Valerie et al. "Outbreak of Atypical Pertussis Detected by Polymerase Chain Reaction in Immunized Preschool-Aged Children." Pediatric Infectious Disease Journal. 28(7):582-587, July 2009.
8, "Many whooping cough victims have been immunized; Experts spar over prospects of new disease strain," by Kevin Crowe. Published December 13, 2010
9. "Blurred lines of Influence," by Kevin Crowe and Roxanna Popescu. Published December 14, 2010.
10. Ibid. "Blurred lines of influence."
11. Ibid. "Blurred lines of influence."
12. National Network for Immunization Information. "Adolescent and Adult Pertussis Vaccines." December, 2006.

Source of above article: http://newswithviews.com/Tenpenny/sherri128.htm

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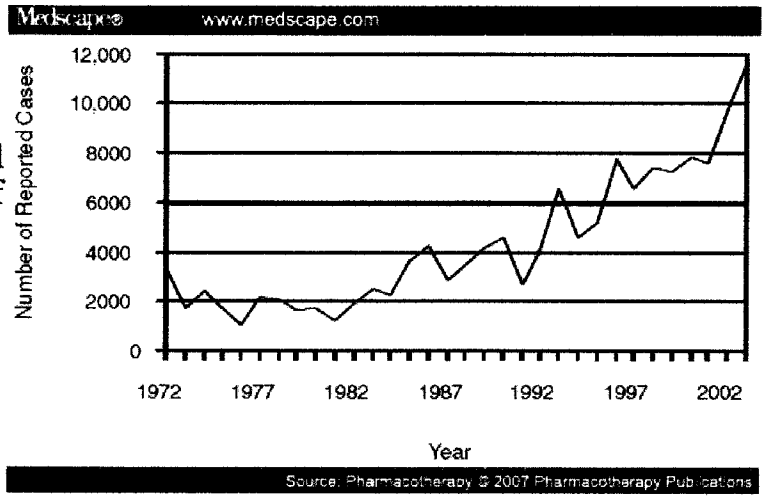
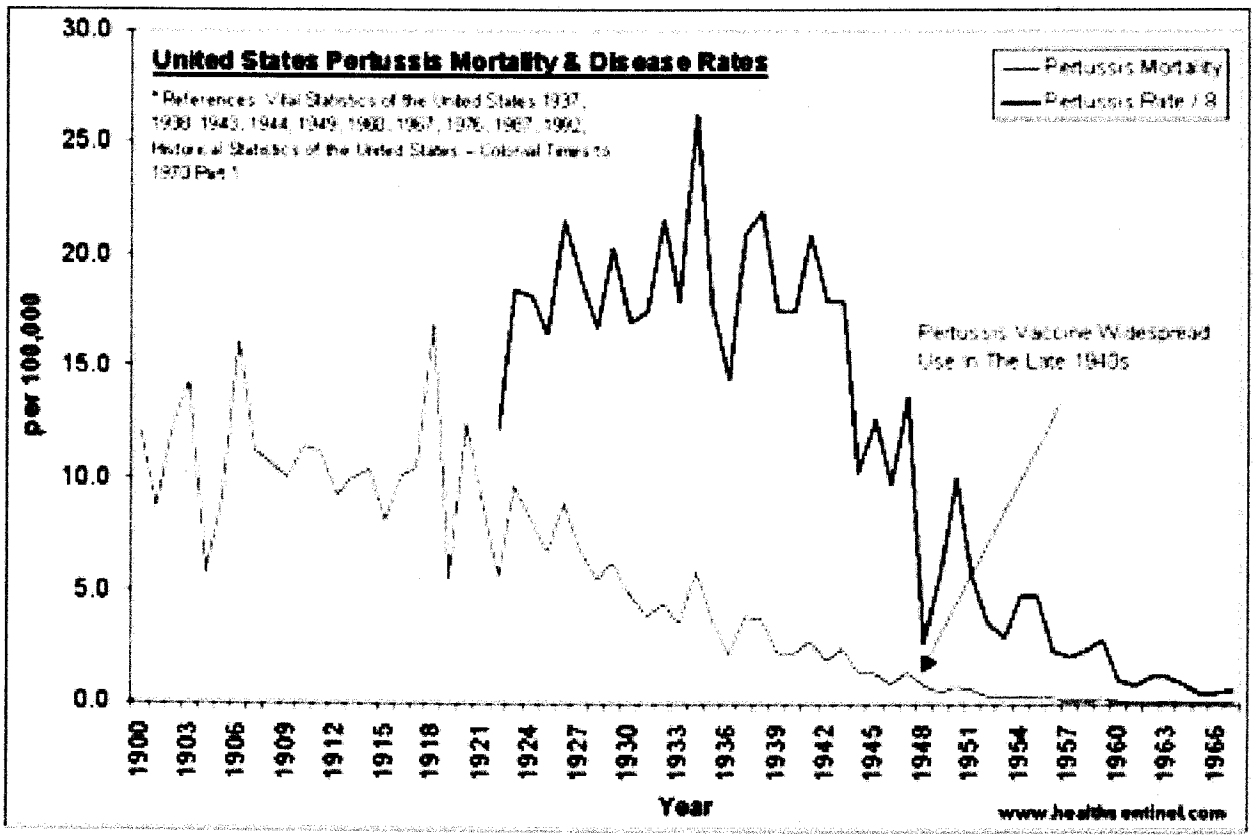
Some Graphs:

Reported cases of Whooping Cough.

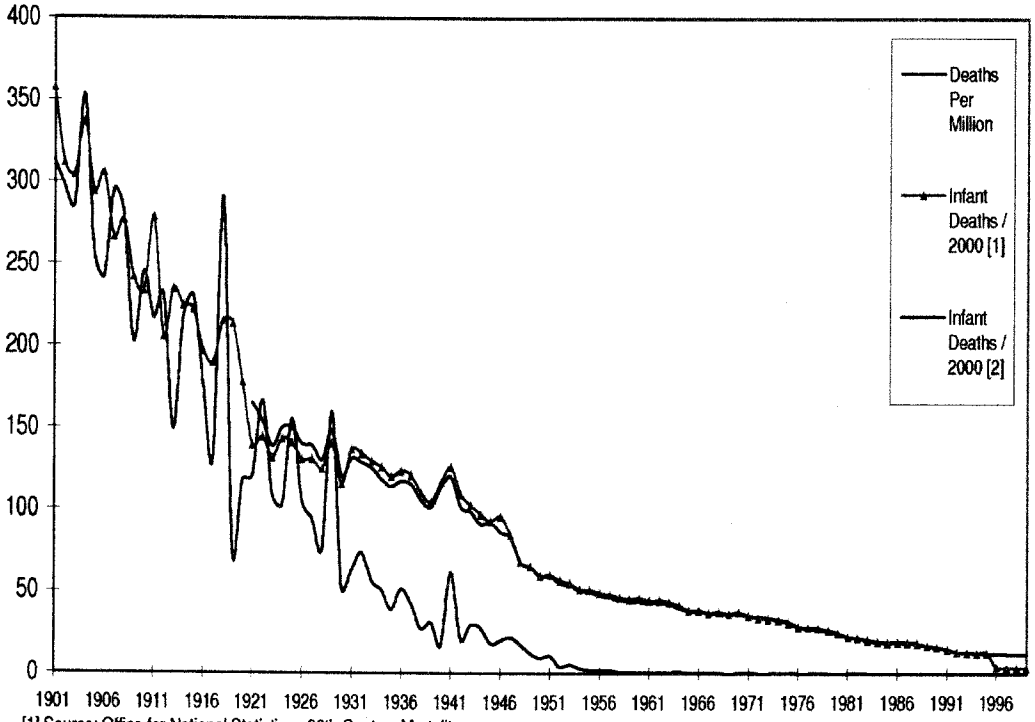
Note that the lowest number of reported incidents was in 1977 and the number of reported cases has been rising since 1980. Cases are typically mild and are seriously under-reported.

Source: Medcape.com





Whooping Cough - Mortality Per Million All Ages [1] vs All Infant Mortality all causes per 2000 infants [1] - England & Wales 1901-1999



[1] Source: Office for National Statistics - 20th Century Mortality

[2] Series DH3 No.38 - Table 33 - Mortality statistics - Childhood, infant and perinatal, Review of the Registrar General on deaths in England and Wales, 2005

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SYNOPTIC OVERVIEW:
ISSUES IN IMMUNIZATION THEORY AND PRACTICE

Prepared by: Raymond Obomsawin
November, 2009

IMMUNIZATION THEORY ISSUES

Theory:

Vaccination is the injection of antigenic material, such as pathogen derived foreign proteins and toxic adjuvants into the body, to initiate a *"learned"* immune system response in order to prevent particular diseases. Memory T cells (cell-mediated immunity) and Memory B cells (humoral-mediated immunity) learn to respond more quickly and strongly to specific infectious agents. B lymphocyte cell response to infectious agents are dependent on intelligence from memory T cells which serve as *"helpers"* aiding in the recognition of intrusive pathogens by signaling to B cells to produce *"high affinity antibodies".* http://www.microrao.com/micronotes/pg/humoral_immunity.pdf

Facts:

University of Chicago researchers found that Memory T cells are *"distressingly slow learners"*, requiring *"several generations"* of intensive stimulation to make a lasting impression on T cells "*No vaccine trial to date has been able to produce significant numbers of memory T lymphocytes…"* University of Chicago Medical Center; T-cell memory finding may provide key to cancer, AIDS vaccines; March 11, 1999; http://www.uchospitals.edu/news/1999/19990311-tcell-memory.html

The Pasteur Institute found that *"98% of the immune responses triggered at the early stages of infection are non specific. These non specific responses had been observed following different infections by viruses, bacteria, parasites and fungi."* This means that natural immune system affords 98% of the early response to an infectious disease agent, while the adaptive or memory-based protective response that vaccination seeks to stimulate represents only 2% of early response. Pasteur Institute Press Release – Towards new vaccination strategies based on 'non specific immunity'; August 1, 2000.

The Center for Vaccine Research in Pittsburgh, Pennsylvania confirms that *"Vaccine induced enhancement of infection and disease has been reported for a number of viral pathogens."* The production of antiviral antibodies can fail to inactivate infectivity and actually "enhance" the entry of certain viruses (including Coxsackie virus; Respiratory Syncytial virus; Rabies virus; Influenza A virus; Epstein -Barr virus and Herpes Simplex virus) into target cells and increase infectivity and worsen disease symptoms. Whether antibodies neutralize or worsen viral infection depends on a number of factors, including virus strain and dose, host cell–antibody combination, and the concentration and class of the antibody. Takada A. and Kawaoka Y.; Antibody-dependent enhancement of viral infection: molecular mechanisms and in vivo implications; Reviews in Medical Virology; No. 13; 2003; pp. 387-398.

Children with agammaglobulinaemia have no capacity to produce antibodies after contracting zymotic diseases, but still recover from measles with long-lasting immunity. Burnet M.; Auto Immunity and Auto Immune Disease, M.T.P., London, England, 1973, Chapter 3.

A mid 20th century study on the relationship of diphtheria incidence to the presence of antibodies found no observable correlation between antibody count and onset of the disease. ***"The researchers found people who were highly resistant with extremely low antibody count, and people who developed the disease who had high antibody counts."*** Report No. 272, British Medical Council, London, England, May, 1950.

A group of military recruits were immunized for Rubella, and uniformly demonstrated antibodies, however 80 percent of the recruits contracted the disease when later exposed to it. Similar results were demonstrated in a subsequent study conducted at an institution for the mentally disabled. Allan B.; Australian Journal of Medical Technology; Vol. 4, Nov. 1973, pp. 26 and 27

Disease is obviously a broad bio-ecological question which goes beyond whether one is vaccinated, or whether one's body is producing desired antibodies. Scientists have concluded that: ***"It is important to stress that immunity (or its absence) cannot be determined reliable on the basis of history of the disease, history of immunization, or even history of prior serologic determination."*** Polk B.F., et al.; An Outbreak of Rubella (German Measles) among Hospital Personnel, The New England Journal of Medicine, Vol. 303, No. 10, September 4, 1980, pp. 541-545.

These basic findings and observations suggest that there are serious frailties in vaccination theory and practice.

HISTORICAL INFECTIOUS DISEASE DECLINES

The textbook Aboriginal Health in Canada attributes the decline in diseases such as "*measles, rubella, mumps, poliomyelitis, tetanus and diphtheria in Aboriginal communities*" to the "*success of immunization programs*." J.B. Waldram, D.A. Herring, and T.K. Young, Aboriginal Health in Canada: Historical, Cultural and Epidemiological Perspectives, University of Toronto Press, 1995, p. 75.

A large body of historical epidemiological data shows that major declines in most major infectious diseases took place in the western world before the use of specific vaccines. In the mid 20th century it was observed that ***"The decline in diphtheria, whooping cough and typhoid fever began fully fifty years prior to the inception of artificial immunization and followed an almost even grade before and after the adoption of these control measures. In the case of scarlet fever, mumps, measles and rheumatic fever there has been no specific innovation in control measures, yet these also have followed the same general pattern in incidence decline."*** **Claims about the historical life-saving impact of immunization programs appear to be assumptive and not factual.** McCormick W.J., Vitamin C in the Prophylaxis and Therapy of Infectious Diseases; Archives of Pediatrics, Vol. 68, No. 1, January 1951

Cause-specific mortality reports show that although life expectancy had increased by 23 years during the first half of the 20th century, actually no more than a year or two were actually attributable to advances in medical interventions. Bunker J.P., Symposium: The Role of Medical Care in Contributing to Health Improvements Within Societies, International Journal of Epidemiology, 2001, No. 30, pp. 1260-1263.

INTER-SECTORAL DETERMINANTS OF HEALTH

The success of any genuine effort to alleviate infectious disease among socio-economically marginalized populations must prioritize the inter-sectoral determinants of health. ***"Involvement of specialists other than the traditional healing professions; water, food, housing, sanitation and education are all important prerequisites for health."*** Helberg H., An Evolving Process, in World Health, Published by the World Health Organization, Geneva, Switzerland, Jan. - Feb. issue, 1988.

"To assess priorities in health policies... the chief requirement is therefore to come to a conclusion about the reasons for the decline of the infections... All the countries that advanced rapidly achieved a substantial improvement in nutrition, which led to increased resistance. Indeed in some countries this was the only important direct influence. It is perhaps surprising that immunization appears to have contributed relatively little to the advances..." McKeown T., The Road to Health, World Health Forum, Published by the World Health Organization, Geneva, Switzerland, Vol. 10, 1989, pp. 410 and 411

"The most likely factors leading to health improvements...are a rise in the levels of nutrition and the slow spread of modern ideas of personal hygiene... the principal factor behind the improvement in health... in developing countries is probably not any form of health measure, but economic development itself... Mere exposure to a disease agent need not produce clinical disease and very frequently does not do so." **Malnutrition is of the highest importance because it hampers the body's natural resistance and acts** ***"synergistically"*** **with disease agents to increase the incidence and severity of clinical diseases.** Sharpston M.J., Health and the Human Environment, in (Ghosh P.K. editor) Health, Food and Nutrition in Third World Development, International Development Resource Book No. 6, Greenword Press,, Westport, Conn., U.S.A., 1984, pp. 85 and 80.

Vaccines or no vaccines, without improving the standard of living, and particularly nutrition status, children will frequently succumb to infections, and have repeated relapses. For primary prevention, public health education, enhanced nutrition status and environmental sanitation deserve the highest attention. ***"For obvious reasons, the highest priority must be given to preventive measures... The final and permanent answer to the problem will rest in... social and economic development... taking into account the need for nutritional improvement of the present generation. If good nutritional status is maintained in the first years of life, successive attacks of most infectious diseases of moderate virulence will probably produce no more than mild effects."*** Standard K.L., Infections and Malnutrition in Child Mortality, in Epidemiology and Community Health in Warm Climate Countries, Cruickshank R., et. al. editors, Churchill Livingstone, Edinburgh, UK, 1976, pp. 45-48.

ADVERSE EVENTS MONITORING & LONG TERM ADVERSE EFFECTS

Although Canada has in place passive and active surveillance provisions, the chronic under-reporting of vaccine-induced morbidity, disability, and mortality appears to be the norm, with many vaccine reactions being unreported and undocumented. ***"Precise data on the risk and incidence of adverse reactions are relatively difficult to obtain,... [and] what is known with certainty about the causality and pathogenesis of vaccine-associated adverse events (VAAEs) is quite limited."*** **Although the occurrence of** ***"late"*** **or long-term vaccine adverse events in some vaccines is incontestable,** ***"a major limitation of all the current approaches to monitoring VAAEs is the insensitivity or outright inability to detect events caused or initiated by vaccination which manifest more than 3-4 weeks after vaccination."*** Ward, B.J., Vaccine adverse events in

the new millennium: is there reason for concern?, Bulletin of the World Health Organization, Vol. 78, No. 2, 2000, pp. 205-207.

There has never been any community-based research in First Nations on the nature and extent of vaccine adverse events which are occurring. This represents a major research gap. ***"Significant adverse effects have been reported with every type of vaccine. These reactions may occur soon after vaccination or several months to years later. Delayed reactions are more insidious and less obviously linked to vaccination and thus necessitate large-scale epidemiological studies to be proven."*** Null, G., and Feldman, M., Vaccination: An updated Analysis of the Health Risks, 3 part series Townsend Letter, online Oct., Nov. & Dec. issues, 2007, http://www.townsendletter.com/Oct2007/vaccinate_null1007.htm

Because in the immunization procedure foreign pathogenic proteins and toxic adjuvants are placed directly into the body tissues and circulatory system, without censoring by the liver, this gives them accessibility to the body's vital organs and systems as well as the brain. ***"Studies have linked neurodegeneration and a worsening of neurodegenerative diseases to systemic immune activation."*** **Science now understands the inks between systemic immune activation with vaccines, brain microglial activation, and major depressive disorder and a worsening of neurodegenerative diseases.** ***"A number of studies have shown that live viruses used in vaccines can enter the brain and reside there for a lifetime... These viruses can trigger brain inflammation and degeneration - that is, there exist a chronic degeneration of the brain over years or decades. Because the resulting condition is so far separated from the time of administration of the original vaccine, physicians attribute the degeneration to old age or heredity."*** Blaylock, R.L., Vaccines, depression, and neurodegeneration after age 50 years: another reason to avoid the recommended vaccines, Medical Veritas No. 5, 2008, pp. 1742–1747.

At the following URL will be found access to copies of dozens of peer reviewed medical journal citations and articles on adverse effects associated with the following vaccines: Chicken Pox/varicella, BCG (TB), Cholera, Diabetes, DPT, DT & Polio, DTaP, Encephalitis, Hepatitis B, Hib, Gardasil, Influenza, MMR, Measles/rubella, Measles, EZ measles, Meningococcal, Mumps, Polio, Pneumococcal, Rabies, Rotavirus, Rubella, Smallpox, Tetanus, Typhoid, and Yellow Fever. http://www.whale.to/vaccine/citations.html

VACCINES & NEUROLOGICAL DISORDERS

Dozens of published peer-reviewed studies demonstrate clinical and scientific links between vaccination/vaccine ingredients and autism spectrum disorders (ASDs) showing the mechanism by which the damage is done, including on a molecular level. These include cell culture studies, mixed cell cultures, organotypic tissue studies, in vivo animal studies, and human studies. Blaylock, R.L., The danger of excessive vaccination during brain development: the case for a link to Autism Spectrum Disorders (ASD), Medical Veritas, Vol. 5, 2008, pp. 1727-1731.

Mice injected with the vaccine adjuvants aluminum hydroxide and squalene (adjusted for human body weight) by 20-24 weeks, exhibited significant loss in physical strength (50 percent) increases in anxiety (38 percent); memory deficits (41 times the errors as in the control group). One third of the neuron cells controlling bodily motor functions had destroyed themselves. Petrik, M.S., Shaw, C.S. et. al., Aluminum Adjuvant Linked to Gulf War Illness Induces Motor Neuron Death in Mice, NeuroMolecular Medicine, Vol. 9., 2007, pp. 83-99.

Thimerosal (ethylmercury) found in vaccines, leaves double the amount of inorganic mercury in the brain as does exposure to methyl mercury, the kind of mercury found in fish. Burbacher, T.M., et. al., Environmental Health Perspectives, Comparison of Blood and Brain Mercury Levels in Infant Monkeys Exposed to Methylmercury or Vaccines Containing Thimerosal, Vol. 113, No. 8, August 2005, p. 1020. http://www.ehponline.org/members/2005/7712/7712.pdf

The set of psychiatric, speech, cognitive, sensory, motor, and behavioral symptoms used to diagnose autism are consistently comparable to the symptoms that are observed in persons with sub-acute mercury poisoning. Bernard, S. et. al., Autism: a novel form of mercury poisoning, Medical Hypotheses, Vol. 56, No. 4, 2001, p. 463.

Analyses of the (U.S.) Vaccine Adverse Events Reporting System (VAERS), researchers reported 2- to 8-fold increase in risk of autism, speech disorders, mental retardation and thinking abnormalities following vaccination with thimerosal-containing vaccines compared to children who received vaccines with no thimerosal, or significantly less thimerosal. Geier, D. and Geier, M., Early Downward Trends in Neurodevelopmental Disorders Following Removal of Thimerosal-Containing Vaccines, Journal of American Physicians and Surgeons, Vol. 11, No. 1 2006, pp. 8-9.

It was found that the likelihood of children requiring special education services was 900% greater for male children vaccinated with hepatitis B (containing thimerosal) as for unvaccinated males after adjustment for confounders. The learning disability diagnosis rate of 18 percent for First Nations boys (off reserve) is 5 ½ times greater than for non-First Nation boys in Canada. Gallagher C., and Goodman, M., Hepatitis B triple series vaccine and developmental disability in US children aged 1-9 years, Toxicological and Environmental Chemistry, Vol. 90, No. 5, September-October 2008, pp. 997-1008. Bougie, E., Statistics Canada, Aboriginal Peoples Survey 2006 - School Experiences of Off-Reserve First Nations Children Aged 6-14, January 2009, p. 9

Hepatitis B (with thimerosal) vaccination given to males in the first month exhibited a 294% greater rate of Autism Spectrum Disorder (ASD) among those aged 3-17, compared with those getting the vaccine later or the unvaccinated. It was also found that the white population (i.e. Caucasians, excluding Hispanics) were 61 percent less likely to have ASD. Gallagher, C. et. al, Hepatitis B Vaccination of Male Neonates and Autism, Annals of Epidemiology, Vol. 19, No. 9, September 2009, pp. 651-680.

A SurveyUSA 2007 study covering vaccinated and unvaccinated male subjects (over 9,000 males studied, age 4-17) in Oregon and California, showed in the 11-17 age bracket that the vaccinated experienced 158% more neurological disorders, 317% more ADHD, and 112% more autism. The Vaccinated, 4-17 age bracket, were 120% more likely to have asthma. Study confidence intervals were at or above 95 percent. Generation Rescue, California-Oregon: Vaccinated vs. Unvaccinated Survey, http://www.generationrescue.org/survey.html

The cerebellum (senses, coordination and motor control) is much more sensitive to mercury in thimerosal than the cerebrum, thus supporting the biological plausibility that thimerosal-containing vaccines contribute to childhood autism. Minami, T., et. al., Induction of metallothionein in mouse cerebellum and cerebrum with low-dose thimerosal injection, Cell Biology and Toxicology, April, 2009 Apr 9. [Epub ahead of print]
http://www.ncbi.nlm.nih.gov/pubmed/19357975?ordinalpos=10&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_DefaultReportPanel.Pubmed_RVDocSum

Eight of nine patients examined were exposed to significant mercury from Thimerosal-containing vaccines during their fetal/infant developmental periods, and subsequently, between 12 and 24 months of age, these previously normally developing children suffered mercury toxic encephalopathies symptomatically consistent with regressive Autism Spectrum Disorders. Geier, D. and Geier, M., A Case Series of Children with Apparent Mercury Toxic Encephalopathies Manifesting with Clinical Symptoms of Regressive Autistic Disorders, Journal of Toxicology and Environmental Health, Part A, No. 70: 2007, pp. 837–851.

The very large rise in autism cannot be explained by better diagnosis and expanded diagnostic criteria, or genetics but rather is a real event, possibly propelled by environmental exposures to *substances such as mercury; viral exposures; autoimmune disorders; and childhood vaccinations.* M.I.N.D. Institute, University of California, Davis, Report to the Legislature on the Principal Findings from The Epidemiology of Autism in California: A Comprehensive Pilot Study, October 17, 2002, pp. 3-5, and 14. http://www.dds.ca.gov/AUTISM/docs/study_final.pdf

Vaccination: Is the customer ever right?

Answer the following questions from a Consumer's point of view:

1. Which company do you want to make your vaccines?
   A. A company that makes more money if the vaccine is safe and effective, and which takes full responsibility for any adverse reaction from their vaccines.
   B. A company that loses money either if the vaccine fails to cause significant adverse reactions or loses money if the vaccine effectively prevents disease; and federal law has released the vaccine manufacturer of all liability for adverse reactions to their vaccines.

2. Which doctor do you want to administer your vaccines?
   A. A doctor who takes full responsibility for any adverse reactions from vaccines administered by themselves and who has been trained to identify and treat adverse reactions from vaccines.
   B. A doctor who has full immunity from adverse vaccine reactions administered by themselves and who has been trained only to sell vaccines but has NOT received training in identifying vaccine failure, and who has NOT received training in identifying or treating adverse vaccine reactions.

3. Which insurance company do you want your insurance with in the event you or your child is vaccine damaged?
   A. A company which is regulated by consumers and whose policies are in the hands of fellow consumers and parents of vaccine damaged children.
   B. A company owned by the government and whose policies are set to benefit vaccine manufacturers.

4. Which policy do you prefer regulatory agencies follow before licensing vaccines for marketing?
   A. Strict scientific testing proving that a vaccine is safe and effective by defining both a measured benefit (effectiveness) and measured risk over at least a five year post vaccination period prior to licensing.
   B. Licensing of vaccines based on a short period of testing in a small number of healthy individuals with antibody response substituted for measured benefit and safety determined by a two week follow up that compares the passively reported side effects in two groups vaccinated with different vaccines.

5. Which policy is best for recommending vaccine schedules?
   A. Individuals trained in science and having no financial or educational ties to the pharmaceutical industry to determine the efficacy and risk/benefit ratio of each vaccine when making vaccine recommendations.
   B. Individuals who have graduated from schools funded in part by pharmaceutical companies and who have vested interests in the outcome of their recommendations should be given the authority to make vaccine recommendations.

6. State policies for recommending or mandating vaccines are best if:
   A. the vaccines recommended are scientifically proven to be safe and effective, and individual rights to make the decisions about vaccinations for themselves and their children are respected. This policy includes encouraging a significant percentage of volunteers to not vaccinate so effectiveness and long term safety records can be established for any vaccine on the recommended schedule.
   B. Pharmaceutical company profits are of the highest priority and vaccines should be mandated even if efficacy and safety have not been determined. Vaccine decisions should never be left in the hands of parents no matter how informed they may be about vaccine benefits or risks.

The correct answer for the consumer in each question above is answer A. However, the actual existing condition in todays society is answer B. Why is the customer always wrong? Why is the pharmaceutical company ALWAYS given the golden end of the stick? If you believe it is time for the people to have power over their own choices, write your state senators and representatives and demand an end to mandated vaccinations. Also demand that the state stop using tax money to promote pharmaceutical products including vaccines. Vaccine manufacturers can advertise for themselves. Alternative products and procedures always exist to pharmaceutical products. Immunizing with diet and lifestyle is far more effective and safe than using toxic and inappropriate vaccines. Present vaccination recommendations are based on maximizing profit for vaccine manufacturers which, unfortunately, means maximizing disease and minimizing health for the consumer.